STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

TRANSCRIPT OF PROCEEDINGS

STUDY SESSION

May 30, 1997
San Diego, California

ATTENDEES:

STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

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BRUCE W. SPURLOCK, M.D.
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EX-OFFICIO MEMBERS:

KIM BELSHE'
KEITH BISHOP
MICHAEL SHAPIRO
DAVID KNOWLES

ALSO PRESENT:

ELIAS S. LOPEZ, ECONOMIST/DEMOGRAPHER
ALAN E. SHUMACHER, M.D.
ROBERT C. FELLMETH
MEMBERS OF THE GENERAL PUBLIC

SAN DIEGO, CALIFORNIA, FRIDAY, MAY 30, 1997

2:00 P.M.

DR. ENTHOVEN: I'd like to call the Managed Health Care Improvement Study Task Force Study Session to order. We are going to start with Jill McLaughlin, the task force secretary, calling the role.

I'd like to welcome all of you. Thank you for being here. I appreciate some of you had to travel a long way, although we have lovely surroundings here so it's not all bad.

Jill, would you call the role, please?

MS. McLAUGHLIN: Alpert?

DR. ALPERT: Present.

MS. McLAUGHLIN: Armstead?

MR. ARMSTEAD: Here.

MS. McLAUGHLIN: Conom?

DR. CONOM: Here.

MS. McLAUGHLIN: Decker?

Enthoven?

DR. ENTHOVEN: Here.

MS. McLAUGHLIN: Farber?

Finberg?

MS. FINBERG: Here.

MS. McLAUGHLIN: Gallegos?

Gilbert?

DR. GILBERT: Here.

MS. McLAUGHLIN: Griffiths?
Hartshorn?
Hauck?
Hiepler?
Karpf?
DR. KARPF: Here.
MS. McLAUGHLIN: Kerr?
MR. KER: Here.
MS. McLAUGHLIN: Lee?
MR. LEE: Here.
MS. McLAUGHLIN: Murrell?
MS. MURRELL: Here.
MS. McLAUGHLIN: Northway?
DR. NORTHWAY: Here.
MS. McLAUGHLIN: O'Sullivan?
Perez?
Ramey?
Rodgers?
MR. RODGERS: Here.
MS. McLAUGHLIN: Rodrigues-Trias?
DR. RODRIGUES-TRIAS: Here.
MS. McLAUGHLIN: Severoni?
MS. SEVERONI: Here.
MS. McLAUGHLIN: Spurlock?
DR. SPURLOCK: Here.
MS. McLAUGHLIN: Tirapelle?
Williams?
MR. WILLIAMS: Here.

MS. McLAUGHLIN: Zaremburg?
Zatkin?
Belche'?
MS. BELSHE': Here.
MS. McLAUGHLIN: Berte?
Bishop?
MR. BISHOP: Here.
MS. McLAUGHLIN: Rosenthal?
Shapiro?
MR. SHAPIRO: Here.
MS. McLAUGHLIN: Werdegar?
Thank you.
DR. ENTHOVEN: The purpose of having a study session like this is to allow us without all the procedural trappings to focus on substantive issues that need to be considered by the task force. And so what we're hoping to do with each study session is to provide materials ahead of time, to ask for discussions and presentations, and then for all of the members of the task force to really dig in and try to use the opportunity to educate and inform each other about the particular aspect that we'll be dealing with today.
The tentative schedule that we are going to work on is this session is scheduled from 2:00 until 4:30. And we'll spend from now until 3:30 on a discussion of the roles and functions and organization of government in regulating the health

care service plans. And then we'll spend our last hour between 3:30 and 4:30 discussing the work plan and the work schedule.

This is not a meeting for formal decisions. I hope we won't have any motives -- motions other than to adjourn. We'll have lots of motives. And then we can just have some good discussions, and people will feel free to ask questions or make comments and illuminate this whole thing.

So -- and we will reserve some time at the end of each discussion period to allow for general public comment. And we appreciate members of the general public coming here, and you're one of the reasons we've come to San Diego is to hear what you think about this. But I think we need to start out with substantive materials. So we're going to start with the role of government and the organization of government's regulation of managed care.

The role of government in our economy is, of course, vast in many respects. And what we need to do here is to focus specifically on the regulation of managed care. So our first topic of discussion will focus on the role of government in the regulation of managed care.

As you know, regulatory authority over managed care is now disbursed to several different organizations. Indemnity plans are regulated by the

insurance commissioner, and some indemnity plans have a preferred provider insurance feature. So that qualifies as a kind of managed care.

Knox-Keene plans are regulated by the Department of Corporations. Department of Health Services is responsible for the state's contracts with Medi-Cal managed care and for licensing the most significant medical facilities, while individual providers are licensed and regulated by various licensing boards at the Department of Consumer Affairs.

To my knowledge, no state agency regulates medical groups directly as groups. And they are emerging as an important force in the system.

It may appear confusing or puzzling as to why are we starting with this particular topic now, since it might make sense to go through a longer phase of gathering information about how the system works. But we have been asked by the governor and the legislature, who have both requested that the task force provide advice on the subject of the regulatory agency.

I certainly don't expect the task force to come to any firm conclusions today. This is an early look at this issue to which I would expect the task force to return at a later meeting or meetings, because we are being asked by sometime in mid August

to come up with recommendations, if we can, about where to go on this.

I'd like to suggest that today, although we'll be looking both at where the regulatory functions repose, that we try to focus on what the regulatory agencies actually do and should be doing and try to understand that, get into kind of the meat of the kind of regulatory activities.

So we're going to start with Ms. Hattie Skubik, who is Deputy Director for Policy and Research for the task force, and ask her to begin the discussion related to the role of government and the organization of government's regulation of managed care. Hattie has worked in a number of state governments on health policy issues. She has a master's degree from the Kennedy School at Harvard and is a very knowledgeable person about the subject.

After Hattie, then Mr. Elias Lopez is going to present his findings on the subject.

So we'll turn it over to you.

MS. SKUBIK: Thank you. I would like to draw all of your attention to this handout, which you should have. And for those of you who don't have it, the non-task force members, Teresa Shaw will provide you with a copy.

Basically, we have an incredibly quickly evolving and dynamic health care marketplace. And I think that's what we're all grappling with.

And I think that's why the governor and the legislature was willing to ask that a group of experts come together and do some serious thinking about the appropriate role for government and how we can maximize that role, are we doing the best that we can for the consumers of California.

Right now you have a spectrum of model types. Very simplistically - and this is on your handout - we've got the closed panel HMO's on the left end of the spectrum, which has no connotation, and you have the fee-for-service model on the right hand of the spectrum. If you think of it, this is sort of a spectrum of choice, and it also has connotations related to price.

As you limit choice along the spectrum, you have an effect on the cost structure. So, generally speaking, the more limited the choice, the lower the cost. And I'm sorry if my back is to you, but you really have all of this in front of you.

I have to thank Elias Lopez for doing the computer work on this. It's an excellent job.

At the top of this chart you have a federal regulatory structure that we've got to be in line with. And within that we have our own complex regulatory structure.

So, generally, on this handout, rather than trying to re-draw it in front of you all here now, you find that the marketplace is integrating

vertically to include financing as well as delivery.

And the question that I think we have to ask today is how do we maximize the role of government to make sure that we are doing a really good job overseeing all the various components. And we need to recognize that although it may seem very complex the way it's organized now, that isn't necessarily a bad thing.

I'd like to also draw your attention to the organizational chart, which I actually had copied off of the back of a state telephone directory. I tried to get a computer version for you all to make a more elegant version, but that was not readily available to us.

As you can see, you have the Department of Insurance here. And I won't go through the whole chart, but that's just a good background piece for you all to keep in mind. Generally speaking, you have the Department of Corporations overseeing the prepaid health plans and the Department of Insurance overseeing fee for service.

Now, what Professor Enthoven said moments ago was that the medical groups are increasingly playing an important role. So I just -- I don't want to go into too much detail with you all here today, but I just want to sort of set the stage that you have a vertically integrating market, and you have to make sure that the regulatory structure

does a good job overseeing all the components.

And just to get into some detail on the matter that's very important to all of us, we, the task force, have asked Elias Lopez, who is an economist tomographer with the Health and Research Bureau and an arm of the government that - I hope I say this right - does work for -- research work for both the administrative and legislative branch. So what we've asked him to do is take a look at the critical oversight functions, particularly focusing on the consumer grievance process.

Because I think a lot of what we're hearing is a level of complaint that has raised an alarm bell. And we want to make sure that we are doing the best we can to get a handle on the kinds of walls that consumers might be hitting so that we can be effective at addressing those.

So rather than focusing on boxes of government, let's focus on the whole of government and how we can work together to do a really good job for consumers.

Elias, if you would present your materials. Thank you.

DR. ENTHOVEN: Thank you, Hattie.

MR. LOPEZ: I have about 50 pounds of handouts.

DR. ROMERO: As a fellow economist, I want to congratulate Dr. Lopez on having charts.

It's obligatory. An economist can't make a presentation without handouts.

MS. SKUBIK: But our real goal, along with giving you a little bit of information to start you off, is to get the task force members to actively discuss their vision for how we can make things better.

DR. ENTHOVEN: And the handout indicates Dr. Lopez is with the California Research Bureau and the California State Library and is being very helpful to us in organizing material on many of these issues. Dr. Lopez?

MR. LOPEZ: Thank you, Hattie.

I hope I'm not invading your middle space here so I hope you'll be kind to me.

I made three sets of handouts. The first handout is what I've presented in the April 22nd meeting. And since some of the legislative appointments were still not present at that meeting, I brought that handout. And I made some modifications to Page 3, in which I put the Department of Corporations, the Department of Insurance and the Department of Health Services. The Department of Health Services was not on that handout before. Now it is.

And so that's -- I will not be going into that handout today, but that's the first handout. That's Regulatory Overview Part 1.

The second handout is the one I'll be talking about today, which is the consumer grievance part. And the third handout is a preview of what's to come.

Now, let me give you some background. First, let me briefly introduce myself. I work for the California Research Brueau. And we are modeled after the Congressional Research Service. And we've been asked to look into the California codes to the insurance, to the Department of Corporations and to the Department of Health Services, Medi-Cal, and try to do the comparison of the codes and try to make some sense of it and see where there's overlapping material.

So that's what I've been doing this last month or so. And if you see a few less hairs on my head, well, I hope somebody has the budget to buy me a toupee.

DR. ROMERO: Not covered.

MR. LOPEZ: Not covered?

MR. KNOWLES: I've tried.

MR. LOPEZ: Now, let me begin with the presentation. And you should should all have the Regulatory Overview, Part 2.

MS. SKUBIK: Does anybody still need that Regulatory Overview Part 2?

DR. ENTHOVEN: There's extras over

there.

MS. SKUBIK: Even without the handout, I think you can go ahead.

MR. LOPEZ: My purpose here today is to try to give you some benchmark or some starting ground so that there can be some points where we can start conversing about the issues. And so what I've done is I've taken -- I've gone through the codes of the insurance code and tried to look for the health point related aspects and the consumer grievance components.

I went through the Knox-Keene Act, and I went through the consumer grievance components. I went through the Health, Welfare and Institutions Code, the code relating to the Medi-Cal population. And I went through the consumer grievance process and tried to outline that.

So what you see before you on the Regulatory Overview, Part 2, if you turn to Page 1, basically, it's a three-step process. The step number one is, if I'm a consumer and I have a complaint, I go first through the health plan. That's basically how it works on the three requirements. Some do it more formally than others. But the first step is to go through the health plan.

The step two is to go to -- if it doesn't -- if my complaint doesn't get resolved with the insurer or with the health plan, I go to the

state hotline. And I call their 1-800 number, and I get assistance from them. And I request the assistance.

And then step three is basically the state makes a decision whether to go with the complaint, in favor of the complaint, or against.

That's the general process. If we turn to page 2, there's a lot of information on page 2. And on page 3 you have three departments there side by side. And excuse me for the small lettering, but in order to fit all that information on one page, it was necessary to do the small lettering.

But if we start with the Department of Insurance on the left-hand side, for instance, if I'm the consumer, I first have to go through the health insurer. It is recommended that I go through the health insurer. If that -- if I don't get a satisfactory answer from the health insurer, then I can call the 1-800 number of the Department of Insurance. So that's the middle box.

So now I go to the middle box. Then the department mails me out a request of assistance form. The enrollee mails me -- the enrollee mails back the request of assistance form back to the department after they've filled it out, and then the department reviews the complaint.

And then on the third box it's the department makes a final action on it.

If we go to the Department of Corporations, the process is similar except that you have to go more formally through the health plan grievance process. So the first step is to go through the health plan grievance process of the health plan. The health plan has 60 days in which to resolve the complaint. If they don't do it within 60 days, then they can call the Department of Corporations, the 1-800 number.

Then it's the same process. The department mails out a request of assistance form. If I'm the consumer, I fill that out. I send it back to the Department of Corporations. They review it. And then the department makes a final disposition of it.

Now, if we go to Medi-Cal, the department is regulated by the Department of Health Services. That's the right-hand side of the column. We have the same process. You go through the health plan grievance process of the health plan. The difference here is that the health plan has 30 days to resolve the complaint. They go through the Department of Health Services after 30 days. They call the 1-800 number that they have.

And the difference here for the Department of Health Services is that they take both written complaints and they take complaints by phone. So you don't have to send out a request of assistance

form and mail it back, fill it out and mail it back. So they take complaints over the phone.

Now, they are able to do this because they have on-line the Medi-Cal files of the recipients. So they're able to see what type of health coverage they have, and so they can have a more streamlined process. So there's the benefit of having the Medi-Cal process is more streamlined in that they have the capacity to review the coverage of the recipient on-line.

The Department of Corporations has an advantage in that, in reviewing the codes, I for one appreciate it when I went to review the codes that the material for consumer grievances was in one place. I didn't have to go through various sets of codes, or I didn't have to consult also with the regulations. So it was all in one place. And, also, there was a set of -- a set time frame for resolving the complaints.

The Department of Insurance, the strength of the Department of Insurance, is that they don't have to really go through formally a length of time grievance process. If they don't get a satisfactory answer from the insurer, they can call the Department of Insurance.

This is, in a nutshell, the consumer grievance process or a comparison of the three departments. Now, this is -- I can't say which

department or which consumer grievance process is better. I don't have the data to try to say which customer satisfaction -- which sets of customers feel better with what type of consumer grievance. So I don't have that information so I can't say that.

What I could say, however, if you turn -- if you look at page 2 again is that, as a consumer, it is not a very consumer oriented process in general. Because if you call the Department of Insurance, the Department of Insurance could say, well, it's a Knox-Keene Act, you're under a managed care; well, you call -- you have to call the Department of Corporations. Well, the Department of Corporations could say, no, it's a Medi-Cal situation so you call the Department of Health Services.

So even though the system for one of the departments might be very efficient in itself, the system as a whole is not very consumer oriented in that they're bounced around. There's the possibility of being -- yes?

DR. SPURLOCK: Do you know how much that happens --

MR. LOPEZ: No, I don't.

DR. SPURLOCK: -- how long they get bounced around?

MR. LOPEZ: Now, it --

DR. ROMERO: Mr. Chairman, I'd like to address a related issue.

DR. ENTHOVEN: Yes?

DR. ROMERO: This one is to Hattie.

Are these kinds of stovepipes determined to be more or less of a consumer problem?

MS. SKUBIK: That's a good question. I don't know the answer to that, but I would just say that that would probably be a fairly doable change for us to consider is to say, you know, there would be one phone number where an intelligent person at the other end of that phone could cycle the person to the right place. I mean, that seems like a very simple reengineering question.

MR. KNOWLES: Is this person a state employee?

MS. SKUBIK: Absolutely.

DR. ENTHOVEN: I was imagining you'd be, but after you got past that, if you're at a DOI regulated place, push the Knox-Keene.

MS. SKUBIK: And a more serious answer to David's question whether or not this would be a government employee, I think that's up for grabs. If the private sector can do a better job, if we can contract that out, hey, we should be open to lots of alternatives

DR. ENTHOVEN: I thought what David was getting at is, if you are covered under Cal-PERS, you also have that organization to help you out. They take employees' complaints and seek resolution also.

DR. ROMERO: But this is just an example to foreshadow the later discussion. You can think in terms of coalescing responsibility by putting it all in the same organizational box or by putting some sort of overlay, like consumer intake overlays, as Hattie was describing, to do it. If you use a gatekeeper, to use a term familiar here, you could then have that gatekeeper send the consumers to the specific box that ought to have that responsibility.

DR. ENTHOVEN: Peter?

MR. LEE: Just not to ask a question but just to flesh out some of the complexities, this is a great chart for a starting point, but some of the layers in here is really -- before the health plan starting point is really the individual provider. That's where most people do go to solve the problems.

DR. ROMERO: Very good point.

MR. LEE: That's where most consumers go. The medical group fits in here, and very often health plans say we won't take your complaint until you try to resolve with your medical group. That could also be under the DOC. And they have -- maybe they've only been to the medical group and not the health plan. They don't necessarily know the difference.

The other is the complexities between

anywhere in here, not just PERS, but there's a lot of other players that consumers can go to that we don't know how effective they are: Insurance brokers, employers, groups like PERS that are sort of group purchasers. A number of those have services to help consumers. How well they do it there's a big question about.

The other sort of additional columns on this page I think sort of are needed to flesh it out is that there's people in Medicare and there is a range of -- there's a whole bar there for people on Medicare. It doesn't end up in the state. It ends up in HCFA. But it's similar to Medi-Cal. There's independent groups funded by the state called high caps that help people resolve problems for Medicare.

The other sort of confounding factor is if people are in plans that are self-insured, they might end up in some levels at the Department of Labor under the federal government and be bounced out of these, whether they would appropriately otherwise be in DOI or in DOC and they say, sorry, we're self-insured, we're out of your ballpark for this issue and be kicked over entirely. And the DOL isn't a place to appeal something, though in theory they review patterns of complaints about self-insured plans.

Those are -- this is a great sort of overview, but it's to get at how complex these issues

are and how little we know about what's working and what's not in one of the major -- I've got other comments I'll get into later, but these range of providers, consumer services, both vertically and horizontally don't collect out in data the same way, nor do they share data.

So when we talk about what do we know about in terms of the types of information groups are directing and how well they're collecting, how well they're sharing it at each level is a real sort of a state of confusion, I think, right now.

DR. ENTHOVEN: Rebecca?

MS. BOWNE: But isn't the real issue here we have a complex system? We can't expect one answer for all, but could we not put into effect something that would hold accountable whatever your insurance mechanism or health plan mechanism is that it is the responsibility of the plan to adequately inform each and every consumer as to what is their method of grievance, not that we necessarily need one single method that's going to fit all the different types of plans but that there's something that is charging each way of delivering services with getting the information to the consumer in an understandable, clear format in whatever meets that consumer's needs of what to do?

And my understanding is - at least we've certainly been hearing in the paper - that the

Department of Corporations has been fining a number of health plans for lack of doing that so therefore enforcing that.

I think we heard at our first hearing in the Medi-Cal program that apparently we could use a little bit of improvement there in the communications. And, again, that's a difficult -- it can be difficult to communicate with so we need to take extra, additional steps there.

So I think it's really not that we need one simple way but we need whatever way it is communicated.

DR. ENTHOVEN: Clark?

MR. KERR: It's just one may use mail and voice and the other use mail. Is mail a barrier for people or for some groups? Just the fact of having to write stuff down and receive forms, are some groups suffering because that's a barrier? Do we have any data at all that would indicate that's a problem or not? I'm just curious because in --

MR. RODGERS: Certainly, with the Medi-Cal population as much as 25 percent use post office boxes or use addresses that aren't their home address.

MS. BOWNE: But they have a mechanism but --

MR. RODGERS: Yes, but that --

MR. KERR: I'm wondering if some of the

-- does that lose some potential inquiries that don't happen because it's mail.

MR. SHAPIRO: We had an oversight hearing on the Department of Insurance last October when their budget was substantially reduced for a number of reasons, and they had to become more efficient in their consumer services division.

One of the things they started to do which they hadn't actually done traditionally was require the consumer who called in the 1-800 number to submit a request for assistance. If you didn't follow through on that written request, you didn't get the help that you might need.

That had a significant attrition rate, which allowed them to become more efficient but at the expense of not having the resources to do over the phone what they traditionally did. And that was one of the concerns we had, that, in fact, it wasn't so much an efficiency tool; it was a basically way of dealing with inadequate resources to do what they traditionally had done poorly.

So I think there is some concern that, while request for assistance does mean you're going to have forms - and they are good forms - there is an attrition impact when you do that as opposed to being able to pull up information about that plan, about that enrollee at the time. And they may not be capable.

You're basically weeding out those folks who have the discomfort with bureaucratic paperwork. So I think that there is an impact.

DR. ENTHOVEN: Dr. Karpf?

DR. KARPF: I think it may be important to make complaints, but from our point of view, it may be important to track complaints, go into some of the bureaucratic and individual problems. But what we need to focus on is the issue of whether there are patterns, whether there are systems issues that can get identified through evaluating and thinking through and studying the complaints as opposed to just documenting them.

So whatever we come up with, I think it has to give us insights into the system that allow us to monitor and improve the system.

MS. MURRELL: As a point, to kind of paraphrase Michael a bit too, do we have any idea of the numbers of complaints that go through each one of these and if they are categorized in any particular way so that you can see how the -- you know, see where the complaints fall, if we've got their major categories that the complaints fall into?

MR. LOPEZ: I think the departments themselves might be able to answer that.

DR. ENTHOVEN: Keith had his hand up and probably --

MR. BISHOP: I'd just sort of like to

answer a couple of questions, one on the writing. One of the things that's somewhat unique to us is that the kinds of complaints we get may be coverage complaints or they may be quality-of-care complaints. So oftentimes to evaluate the complaint we need to look at medical records.

I'm not sure how much Department of Insurance, which is more concerned with coverage kinds of issues, needs to look at medical records. But we need to get a signed medical release form in order to get access to the complainant's medical records. So there is a paperwork part of that.

In terms of the complaints and complaint data, we are required and put out an annual complaint report. Last year was the first year we put it out. Our complaint report will probably come out next week for last year. The complaint report divides the complaints up into 32 different categories and is by both full-service and specialized plans. And then we look at the number of complaints per 10,000, which provides some indicia of data.

Other ways that we have just for interfacing with the department, our complaint form is available on the internet. You can download it. And we do allow faxing of complaints for people who want to fax.

And then just a couple of other just

quick comments about what Peter was talking about, the multi-jurisdictional aspect. That is, you know, we handle complaints that may also be in the purview of Medicare or Medi-Cal, and there may be private rights of action that are being pursued all at the same time, arbitration or lawsuits.

So there can be a number of things going on. And it may not be that there's just one agency that has jurisdiction. Medicare, HCFA, the Health Care Financing Administration, and the DOC may both be looking at the same complaint at the same time. Of course, they're a federal agency.

The other thing I'd like to say about this chart is it doesn't end actually at the department's final disposition. What happens, at least for us, is the complaints can be referred to our enforcement division, which could then pursue either an administrative action or go to court, a civil action, against the plan for a perceived violation of the Knox-Keene Act.

Or that complaint -- that could happen as an individual action just based on that one complaint. Or we may see a pattern develop, and then we may take a bunch of the complaints and pursue -- aggregate them and pursue that all as one broader action against the plan.

The other thing that happens is it goes into a medical survey process in which we would look

and see whether there's a deficiency in the way the plan is operating and have that addressed as a deficiency that needs to be corrected as part of our administrative regulatory process. So it just doesn't end necessarily with our review of that individual complaint.

DR. GILBERT: To add to Peter's complexity, the vast majority of complaints handled by medical groups the health care is fine, but the deal is we classify the vast majority of complaints -- the original classification or assigning of what the type the complaint is is generally done by the HMO. So if we don't think about somehow creating some sets of guidelines or standards for that, it's the garbage-in-garbage-out problem.

Because if one perhaps chooses to never call something a quality of care complaint versus another plan calls, you know, certain things quality of care versus access versus provider issue, et cetera, et cetera - because there are numerous categories - we're not going to get - because I completely agree - easy access, uniform reporting.

But if what comes up into the system is extremely variable by health plan or by insurer, it's not going to be of any use. And we classify -- because most of the complaints are directed directly to the health plan. So we end up classifying them and reporting them.

MR. BISHOP: Just one other report. I think it was Senator Rosenthal's legislation. Plans are required to file reports on a quarterly basis with the department of complaints that are pending more than 30 days. And that is a -- those reports are filed with the department and are publicly available. They're not gathered into one report the way our complaint report is issued on an annual basis, but there is that data there.

DR. ENTHOVEN: Thank you. Michael?

DR. KARPF: Can we ask Keith to make available to this committee the report that he puts together? And could we ask if the DOI has in fact a tracking mechanism and a training mechanism and see if a report is generated that we could see as well as DHS?

DR. ENTHOVEN: I think that would be great. Actually, the material that Keith gave us at our first meeting did include some long sheets on complaints; right?

MR. BISHOP: There's a new one coming out in another week or so and about to be issued.

MR. KNOWLES: What information did you want from the DOI?

DR. KARPF: I'm sorry?

MR. KNOWLES: The Department of Insurance.

DR. KARPF: Whether the Department of

Insurance also has mechanism for tracking complaints.

MR. KNOWLES: By nature or by volume?

DR. KARPF: By any mechanism it's chosen up until now to see if there's anything that's comparable to this, whether it's better or worse, whether this is a step forward above and beyond what other agencies have done.

DR. ENTHOVEN: Well, I'm happy to ask staff to work with Keith to make sure we get those.

DR. ROMERO: Sure.

DR. ENTHOVEN: I hope, by the way, you all got your copy of Knox-Keene. I was reading it late last night. You didn't get it?

MS. SKUBIK: Perfect for insomnia.

DR. ENTHOVEN: Helen?

DR. RODRIGUES-TRIAS: I wonder if you could elaborate on the enforcement mechanism, and is there a requirement that the plan address some of the systems issues that, you know, may be the reason --

MR. BISHOP: Well, in terms of enforcement, we generally have -- when we decide to take an enforcement action, there are generally two -- one fork in the road. We can go administratively or civilly. If we go administratively, that means that we issue usually a cease and desist order or a notice to levy a fine. And then if the plan wants to contest that, it goes to an administrative law judge. And then ultimately it could end up being appealed in

the civil courts.

If we go the civil route, then we can seek a wide variety of remedies, including fines, appointment of a receiver, appointment of a monitor, other kinds of remedies that we impose that are -- can have significant impact -- people tend to focus on fines because they're easy to get your arms around. But if we, for example, revoke the license, you know, that's a death sentence to the plan because they're out of business. They can't legally conduct business. That's even more dramatic, possibly, than a fine.

If we freeze new enrollments, that is a very dramatic kind of remedy because what it means is that they can't take any more new business, and all their competitors are getting a jump on them.

Last winter we had a case involving advertising. And what we did is we ordered the plan to print a retraction and also not start a line -- the particular line of business that they were rolling out for some period of time. And I think there was also a fine involved in that case, but I think the delay, the competitive delay, also had a significant impact on the plan.

The Knox-Keene Act gives us a lot of different tools in terms of enforcement. And the focus, though, tends to be on fining. But some of these other things can be even more painful than the

fine.

DR. ENTHOVEN: Peter?

MR. LEE: Just sort of to clarify - and also it's a question to both Keith and Kim - in terms of this chart, the final disposition, one of the things who don't know all the ins and outs of Knox-Keene is disposition here. If the department finds that, for instance, a health plan should have made a referral to a specialist but didn't and says this plan is out of compliance with Knox-Keene, it can't order the plan to do that. It can find that it's out of compliance with Knox-Keene, but it can't necessarily tell the plan to change that particular act.

So in terms of a grievance process, to actually have a change for an individual, plans may do that, but there's no way except for them going into an enforcement action to say now we're going to fine you because you can do what you want to. Is that --

MR. BISHOP: To make them do that, we would have to open a formal enforcement action.

MR. LEE: Enforcement proceeding, right. So that's really going beyond the final disposition. As you were noting, this is not the last step, unlike DHS, where they are both regulator and purchaser, with a contractual relationship with its plans. If it disagrees with the plan and gets to

a point and says, no, you should have paid for this, they can say make that referral, do whatever, and the plan will basically do it; is that right?

MS. BELSHE': No, it's not always quite that simple. It's more difficult on an individual basis. Typically, the action is for the department to come back with a plan of correction to address an issue to the extent we think it's not specific to an individual but more systemic. And that's typically more our approach.

MR. BISHOP: The other --

DR. ENTHOVEN: Peter is pointing his finger on a good point. There is is a big difference from a customer-supplier relationship and a regulatory --

MR. LEE: Regulatory relationship, yeah.

DR. ENTHOVEN: Because when Keith is talking about these dreadful things he might do to health plans, I presume very quickly you're going to get a lawsuit based on the Fifth Amendment or some -- you know, you can't take away their license without due process and --

MR. BISHOP: The complaint process is not, as it's structured, a full due process. We gather information from the complainant. We gather information from the plan and make a decision. If push really comes to shove and we open an enforcement

action, there will be, you know, a due process either in the administrative proceeding - because a lot of the hearing is before an administrative law judge - or they'll have a hearing before a civil court judge in a lawsuit.

But the processing in our determination on that complaint does not afford all due process rights to either the person making the complaint or the plan.

And it's also -- I think it's important to remember that while we often find for the complainant, sometimes we find that the plan is in compliance. And we throughout the process, because it is not a full due process situation, want to be careful of the rights of both the plan and the complainant to not prejudice them if they're involved in separate civil litigation. We don't want to do something that will hurt an enrollee's complaint against a plan base if we, based on our review, think that plan was in the right. They may be pursuing their rights in another venue, and we don't want to interfere with that.

DR. ENTHOVEN: Bruce?

DR. SPURLOCK: Without putting up too much data, I was wondering if you could describe what happens when the provider complains and facilities and physician, not just consumers.

MR. BISHOP: Provider complaints, this

process is designed to process complaints that enrollees of plans have with the plan. We regulate the plans themselves. It's not set up to process contractual complaints the providers may have with plans.

What we do -- we do often get provider complaints, and we act on those. We've gotten complaints -- there's a section of the Knox-Keene Act which requires prompt payment of providers. When we get those complaints, we look into them, and we take enforcement action against plans for violating that provision.

It's not part of our 1-800 number process. We usually run those through our enforcement division or through the medical survey process in which those complaints are looked at. And then when we survey the plan, we -- or do our financial examination of the plan, we look at it. But we're not a venue or a court for provider plan contract disputes.

DR. ENTHOVEN: Dr. Northway, did you have anything?

DR. NORTHWAY: Yeah. Just another complicating factor here is some of our poorest and most vulnerable children have illnesses supposedly covered by CCS on one hand but by the HMO's on the other in terms of their regular kinds of illnesses. So they get caught in the middle as to whether the

broken leg is related to cystic fibrosis or whether it's not. And then it turns that they may or may not get care. And it gets very complicated in that regard.

So there's another group of patients here that basically have their bodies divided into two plans. And I think that's an issue that needs to be addressed.

DR. ENTHOVEN: You wish you could have a structure that didn't do that. It's like worker's comp versus your ordinary, acute medical care. Wouldn't it be great if all the sources funneled it into the same medical care organization?

Jeanne?

MS. FINBERG: I was just going to mention a couple more boxes to put on our chart that are kind of important in terms of resolving problems. They're complaints to the medical board and the arbitration process that is present and some that are required in so many plans.

DR. ENTHOVEN: You mean you're talking about within the plan, when you get to the health plan grievance process? Some of them do have -- in fact, I think all the --

MS. FINBERG: Separate from the grievance process, right.

DR. ENTHOVEN: I think all the participating HMO's in Cal-PERS have an arbitration

clause, don't they? Or they used to.

MS. FINBERG: Sometimes it's mandatory, and sometimes it's binding. And that has different consequences too in terms of what the next step is, not to mention torts. But I think we could leave that off the chart.

DR. ENTHOVEN: Yeah.

DR. ALPERT: I just want to echo what Peter said. I think he hit on the crux of the summary of all the things that are being brought up now, and that is that it's the disconnect all along the way in this multifaceted system has reached a magnitude so that the ultimate consumer satisfaction, public protection, however you want to describe it, is now being done by the legislature, commonly.

And if we track the number of events and predict the number of events that will come in the future based on what's before them now, we will see that that's significantly on the increase. And I think he summarized really what our charge is here, that the magnitude of this problem is at that level.

And so as we look at the regulatory process, if we can assimilate all of this, come up with a structure that decreases the perception of the need for that by the public, which ultimately leads its way through consumer advocacy, anecdotes, media sensationalism, et cetera, to legislation to law, which we have now where we are all perceiving that

the legislature is practicing medicine - and indeed they are - that really, I think, is our charge.

I think he really -- when he asked, well, gee, that just -- the resolution there results in the plan being slapped and really the person -- there's nothing to be addressed for the original complaint. And when you multiply that by millions, it results with what we have now. So I think you've really identified what we have to deal with.

DR. ENTHOVEN: You'd like to be able to develop some kind of a case law and principles that plans could understand and act on so that they know. That's one of the things I'm concerned about is do they learn lessons out of this or do they just get burned or do they understand. Right?

DR. ALPERT: I think as I read all the materials that were sent for this meeting, one I was drawn to particularly was the letter from the Center for Public Interest Law in response to the Rosenthal bill. And not that I have -- we can talk about the specifics of bills and so forth later, but they in their letter pointed out a number of things that they thought were appropriate. And I'm just looking at it.

One they itemized as number four which to me is actually number one. They listed subject matter, expertise.

DR. ENTHOVEN: Right.

DR. ALPERT: And I was drawn to that because I think that's what's missing now. This subject requires expertise across the board. It requires expertise in the corporate financial aspects. It requires expertise in the health-related, specific-complaint aspect as to how providers interact with the patients. And I think that whatever we come up with in terms of recommendations, we really need to focus on that.

If we provide wherever that box is on that chart, which has 40 million boxes on it -- wherever we put it and whatever we call it, that's not my thing. And a lot of people here are better at that. But if we put the right expertise in that box, I think that we'll ultimately solve this problem.

DR. ENTHOVEN: Well, could we pursue that, Keith, and just ask what are the qualifications of the -- of your people who do the -- what expertise or how do you define the expertise? Or, alternatively, when they come to work, how do you train them or what do you tell them to do?

Somebody walks in here, and they've just announced that they've gone to work for you. Now --

MR. BISHOP: Well, normally, they're responding to a job opportunity bulletin that has specific qualifications. But, generally, there are sort of three types of professionals that work within

the health plan division. We have a large number of lawyers. This is obviously a very technical act and a lot of legal questions in terms of both on the legal -- so we have lawyers.

DR. ENTHOVEN: But on the dispute resolution people -- okay.

MR. BISHOP: Then we have the -- second, we have health analysts, people who have a background in health care. And then we have financial examiners, people with financial training.

When a complaint comes in the door, it will be -- it may be assigned to a legal counsel if it involves primarily legal issues. If it involves medical-type issues, then it will be referred to a medical consultant, who will get the patient's medical records and will review them and provide advice to the health analyst or to the legal counsel about what happened to the patient.

The medical doctors are employees, part-time employees, of the department. And we try to get them in a wide range of specialties. So that's where our medical -- where we access the technical-medical expertise.

DR. ENTHOVEN: And what are their instructions? Like -- I'm just trying to think under what conceptual framework do they work. Is it enforce the contract or is it do justice or do good or -- I'm just trying to understand.

MR. BISHOP: Well, our charge is to apply the Knox-Keene law. So what we're looking at is --

DR. ENTHOVEN: Enforce the law?

MR. BISHOP: -- enforcing the law.

So when we look at the complaint, we try to identify does this raise an issue under the Knox-Keene law.

And so that's the basic charge is they're trying to look at, well, what does this -- does this have anything to do with the Knox-Keene law, and, if so, was there a violation of it.

DR. ENTHOVEN: And do these decisions get published? Is there some kind of case law that builds up?

MR. BISHOP: Again, this is not formal adjudicatory process. It's not a judge. There's no hearing. Information is gathered from both the plan and from the patient. And then a decision is made by the counsel reviewing it as to whether or not there's been a violation.

MR. KNOWLES: Question on that point. Jeanne earlier mentioned that another box ought to be in regard to arbitration. I just wanted to ask the commissioner at what point in the complaint or the grievance process typically would the arbitration clause be invoked by a plan.

MR. BISHOP: We review it regardless of

whether or not there's arbitration ongoing. In fact, thanks to Mr. Shapiro, we've made that even clearer in our complaint form. But that has been our policy is to process the complaint regardless of whether or not they're pursuing either litigation or arbitration.

Because we are looking for violations of the law, and we have independent jurisdiction to go after that. We're not bound by the fact that it's in arbitration somewhere.

MR. LEE: So in terms of this picture, this first health plan grievance process could continue throughout this, pick up where DOC picks up. So it's not necessarily linear in terms of the process? It could be overlapping.

MR. BISHOP: Right. It could be going on at least three different tracts. They could be pursuing their complaint with Medicare and also with us, and they could have a private lawyer and pursuing it in court or arbitration.

MR. SHAPIRO: It used to be linear in that if the HMO invoked what is otherwise a binding arbitration clause in essentially contracts, all contracts, the Department of Corporations would not deal with your complaint until you'd exhausted that arbitration process, which could take years. The law overturned that and said notwithstanding the arbitration you could go to our department, you could

concurrently go to arbitration but you weren't precluded from going to the department.

DR. ENTHOVEN: Bruce?

DR. SPURLOCK: A couple of points. What I think we're talking about is the tip of the iceberg. It comes down to the definition of a complaint and a concern. As a physician, I see and I hear complaints and questions all the time that I think we resolve very rapidly just with a phone call and a discussion. Many of my colleagues are getting out and schooled in how to improve patient satisfaction. It's become a marketing issue where most of the work is going on in this area.

So when we tackle this, we're really not dealing with the main component. And perhaps it's better that we don't because it's probably more biological medical care that's dealt with at the lower level. And many of my physician colleagues would say once it gets to this escalation we're diverting funds away from needed care to deal with these complaints, which oftentimes don't end up helping the way care is delivered. So I want to caution as to avoid doing that.

It's kind of like malpractice. Most malpractice suits are a function of the relationship and the communication and not a function of the care. And if we really want to make care better, we need to emphasize below the water of the iceberg.

DR. KARPF: I agree with that, but I think we're talking about substantiated. There are lots of unsubstantiated complaints. And they will feed back and help performance and feeding back to make sure the performance is -- and the standards are good.

DR. ENTHOVEN: Uh-huh.

DR. ROMERO: Could I just ask a related follow-up? And I'd like to address this first to Bruce and Michael and anyone else who has a view.

When people complain, some substantial fraction of the time they're complaining about the wrong entity. You know, they will accuse -- they will accuse their plan of denying coverage when in fact it was a decision made at their group level, for example, or vice versa.

Do you have any sense of where most of the misidentifications falls? I mean, who ends up getting blamed unfairly most often --

DR. KARPF: You want to go first, Bruce?

DR. ROMERO: -- the plan or the employers who didn't give them a generous enough plan to begin with?

DR. KARPF: You're assuming that --

DR. ROMERO: This is misidentification. This isn't what is reality. Of those who complain about unreality, you know, when -- what their most

typical misidentification is.

DR. KARPF: I think from my point of view, when I get complaints about the hospital, most of them are disconnected between levels of expectations and what is in fact available and what is in fact appropriate. So you've got to cull through that process first.

So we do get complaints that become substantiated and we need to deal with. That probably is a small number. What Bruce is pointing out, a small number of the real -- of the magnitude of the complaints that we get or the totality of the complaints that we get -- and we do track to see if there are particular areas, particular doctors, particular issues that recur.

DR. ENTHOVEN: Ron?

MR. WILLIAMS: I think the point of view of the member, the member's attribution, is that the health plan is responsible for everything that happens in the system.

DR. KARPF: So does the hospital --

MR. WILLIAMS: I think -- also, I think it's important to focus on what health plans are focusing on by and large. And I think most health plans that I spend time with want happy, satisfied customers. It's hard to have a successful business if you have customers that are unhappy with your services.

I think it's important also to have -- to take a moment and talk about what happens at the health plan level in terms of these types of issues. Typically what happens is a member has some level of concern about something. They will contact the customer service area. A complaint will be written up. They will -- because of the medical record nature of it, we do ask to have that complaint in writing so that we can get medical records.

Often medical records have to be requested from multiple places because most of the time, if there's an issue, it's because there's referrals. You need primary care records. You need specialty. You need lab tests. There's a lot of information required. The people that do this in the health plans are the nursing staff to coordinate the overall process.

Once the files are collected, then usually independent physicians who are consultants who work with the health plans -- typically, they are local practitioners who work maybe five or ten hours a week on a consulting basis with the health plan -- are asked to review the record and develop an opinion.

And it goes something like this. Sometimes the complaint is about the standard of care, was the standard of care that was given in this situation appropriate. And in the end the consultant

will render a judgment about that. Often you'll also get a question about the medical necessity, that the member feels some procedure should be done; their physician feels that it shouldn't be done.

Often also you'll get a question about covered benefits in terms of the member believes that they have a level of benefit for a particular activity that is not something that was purchased by them or by their employer.

And then the next big category centers around administrative issues: The people in the office were rude, they kept me waiting, it took too long, things along that category.

But I would say all of the health plans that I talked to are very interested in trying to address these issues as quickly and in as timely a way as possible. Part of the challenge, though, is this issue of consumer expectations and often just consumer knowledge.

One question I'd like to ask -- I won't ask this group because I know everyone's done it, but when I talk to other groups, I always ask for a show of hands for how many people have actually read the evidence of their coverage, how many people know what benefits their employer have purchased. And I won't ask this group.

DR. ENTHOVEN: I read mine several times, but I can't remember it.

DR. KARPF: Or you can't understand it. You have to be a, quote, expert in health care.

MR. WILLIAMS: Right. There's one I think everyone can understand, and that is the Medi-Cal coverage. I think the DHS has done a great job of everybody to provide a very strong level of clarity. And I think in our case it's a level of clarity to aspire to for all coverages. But if you look at the Medicare, I think there is a level of plain English that is achievable.

That's just to try to give a point of view of the health plan and how the health plan views what it attempts to do in the fact that when these things happen, from the members' point of view, they feel that no matter where in the system the problem occurs the health plan is responsible.

DR. ENTHOVEN: Yes, Jeanne?

MS. FINBERG: I had a question about the Medi-Cal groups. Because it was mentioned as an unregulated group, and I wondered maybe from Keith and Kim, who are here -- and David if you could describe how your -- the regulations that your agencies do have, how they do regulate a medical group and whether you think that the medical groups are regulated. Maybe not.

MR. BISHOP: The medical groups, we do not license -- you have to be real careful about it. We do not license medical groups per se. There are

some large medical groups that have limited Knox-Keene licenses, and that's a recent development.

Getting back to the earlier question of who is -- who has misdirected the claim, at least in our view, when we license health care service plans, we hold them accountable. If they choose to provide their services through a staff model or through a group model or through any other model they still have, ultimately, they're our licensee, and we hold them responsible for delivering the services in compliance with the Knox-Keene Act.

So there's that indirect regulation. Because if the medical group is not performing for the plan, the plan is going to have a problem. And a good example of that was the Carly Christy case, which involved failure to refer to a specialist, which was done initially at the group level. Ultimately, the plan, which was our licensee, paid the $500,000 fine as a result of their group not meeting the requirements of the law.

DR. ENTHOVEN: Who made that judgment call and on what basis, though? And I gather they felt that -- the clinic said they had a urologist who is qualified, et cetera, the family said the urologist is not experienced in children. So somebody had to make a judgment call. Is that by outside medical consultants or who?

MR. BISHOP: Who made the judgment

call?

DR. ENTHOVEN: And on what basis?

MR. BISHOP: Well, the group initially decided that they weren't going to refer to a specialist. And then ultimately it worked its way into the plan, and the plan went along with its group. When we got involved --

DR. ENTHOVEN: To an outside specialist. I thought they said they had their own.

MS. BOWNE: Well, Alain, I don't think that matters for this.

DR. ENTHOVEN: I'm just trying to get an idea of how these judgments get made.

MR. BISHOP: Well, the primary care physician within the group would not make the referral. And then ultimately that decision was ratified by the plan. When we got involved, then our medical consultants looked at it, and we had -- it went to litigation, had a lengthy hearing before an administrative law judge, which sided basically with our medical experts against the plan.

DR. ENTHOVEN: So it's your medical experts that -- yeah.

MS. FINBERG: So using that as an example then, would you say that the medical group is adequately regulated as a result of that indirect relationship that you are enforcing with your licensee?

MR. BISHOP: Well, the plans certainly have a strong interest in ensuring that the medical groups provide --

DR. KARPF: What do we call the medical groups? I mean, there isn't a clear definition of that.

MR. BISHOP: Yeah. And that's -- there are lots of ways that a plan may choose to deliver medical services. It may, like Kaiser, be predominantly a staff model in which they have employed -- the doctors are essentially employees of the plan or an affiliate of the plan. Most other health care service plans today use a group model in which they would contract either with -- sometimes with individual professional corporations or doctors, sometimes with larger groups, sometimes with even larger groups than that.

So it's -- there's a wide variety of the ways a plan may structure its operations. And some may be mixed in terms of being partially a staff model and partially group model.

If Ron wants to answer that from the industry's perspective --

MR. WILLIAMS: No, I think that's an accurate perception. More recently there's been a shift in the industry away from the staff model. Cigna was one health plan that actually divested itself of its staff model. FHP was another that

divested itself of the staff model and Foundation Health.

DR. KARPF: When you get into the IPA model, it's hard to know whether you're dealing with a something or an individual.

DR. ALPERT: I'm very encouraged by the whole nature of the discussion. It was outlined to us as an umbrella regulatory, but we've moved quickly into defining these grievances.

And I'm not surprised at Dr. Spurlock's and Dr. Karpf's comments because I would be in agreement with those in terms of what I see as a physician. But I was thrilled to hear what Mr. Williams said. But as the nature of we're swirling around medical issues, the standard of care and practice of medicine, virtually everything we've talked about in terms of the grievances are related to that.

And as yet, as we look at the regulatory nature as Hattie presented it to us, one of the things we're looking at is whether or not there is any regular -- health related regulatory agency involved here. And as Mr. Bishop has been saying, he's been nicely outlining how they access their health related investigation and process and so forth.

But it seems to me we're defining where maybe our efforts should be moving towards because it

seems to me we should be moving towards all of the grievances that have been mentioned, which are all related somehow to a health care -- and now I have to stop because as soon as I say agency or something, I'm implying things that I don't specifically mean. It's a theme, not necessarily an identifying of compartment. I think if we fail to do that in a large way because of scurrying around, deciding which compartment, then we would have been a --

DR. ENTHOVEN: Right. We want to really get into the guts of this thing to understand --

MS. BOWNE: But I don't want to lose Dr. Karpf's point in that there are two levels of this. There's the resolution for the individual consumer, which is very important, but there's also that aggregation of what's wrong with this picture and the feedback so that something can be done to change the system or that if there are a lot of individuals complaining about the same thing with the same system that some action is taken.

Now, I have that feeling, at least, you know, we will get an annual report that divides it into 32 categories or something here. Could we hear from the other two entities, the Department of Insurance and the Department of Health Services? Is there any aggregation look back, what is this telling us?

Because that feedback loop is what's going to hopefully improve overall so that the same individuals don't keep having the same problem.

DR. ENTHOVEN: Right.

DR. KARPF: I think we have to get beyond that too, because I think what Ron was saying to you is that the forward looking plans are trying to be proactive in decreasing the number of complaints.

MS. BOWNE: Right.

DR. KARPF: And we need to encourage that. So we need to look at the issues that -- or the mechanisms that can be used to minimize the number of failures, minimize the feedback loop.

MR. LEE: What I heard Ron say even more than decreasing them is handling them well and effectively internally. There's always going to be some complaints, and, yes, you want to have systems that make them never come up. But Ron said the good plans resolve effectively and quickly and resolve them so they never get to the regulartory point.

DR. ENTHOVEN: It's an important point. What are your thoughts about what might we do to go further down that road?

MR. LEE: Part of the thing going down that road is good plans are doing better jobs at resolving complaints before anyone needs to go to a regulatory agency. And I've talked to some plans

that note with great -- you know, patting themselves on the back that they overturned complaints at the medical group level 50 percent of the time.

That's great. But my concern is -- and this is what we haven't talked about -- is informing consumers of how they have rights in the first place. The effective system is having consumers that know what their coverage means and that they've got certain rights and now how to exercise them, first with their individual provider but also with their plan.

One of the things that we need to keep in our minds is how are consumers educated to use whatever system there is before we get to the point of starting down any of these paths. A consumer has to understand that maybe they've got a right or they have a benefit they should be getting and maybe not, that they need to have a process to enter into.

And that's a question that I've got is how I think many consumers having an increase or decrease in a complaint rate is not necessarily a good or a bad thing. The issue is what are those complaints about, how are they being resolved, and how are the different entities that are trying to do that playing that role.

DR. ENTHOVEN: Helen?

DR. RODRIGUES-TRIAS: I think that's a very important approach to look at what is actually

being done at the site of delivery. But I think there's another level of quality assurance I hope doesn't get lost, you know, while we're focusing on complaints.

Complaints are indeed, I think, the tip of the iceberg. And complaints do very often relate to the human relations, you know, the perception of people of whether they've been treated with dignity, if somebody spoke to them softly or made them wait too long or saw them right away or whatever. And you may actually have people who don't complain because there's very good PR in that place. But when it comes to actually looking at indicators of quality of care, they may not be doing such a good job.

So I think there also has to be some objective, if you will, complaints being somewhat subjective and then examined for their objective.

DR. ENTHOVEN: Right.

MR. LEE: If I could follow that, the great point of that in terms of the DOC needing to making sure all the plans are notifying consumers equally about the DOC's hotline is that you get the bizarre situation where plans that are very active about letting consumers know about their rights may have higher complaint rates. That doesn't mean it's a worse plan. That's where some of the marketing issues we have -- you need to have a level playing field that all plans are informing their enrollees of

the full range of resources available, internally and externally.

MR. BISHOP: Could I just say that at least as far as the Knox-Keene Act, it's pretty clear that disclosure, what you have to say, is in the Knox-Keene Act. There's a legend that has to go in, and that's what the plans are now putting in. And at least from my perspective, they were required to put it in their evidence of coverage.

But where I thought they were also required to put it in and what was even more important was in their response to grievances. Because most people are not going to spend time worrying about their complaint rights until they have a complaint. And so I thought it was particularly important that the plans get that disclosure in the response to the complaint that they could go to the DOC.

After we rolled out the first enforcement action on this in January, we saw the number of calls to our 1-800 number go from about 3,600 a month to over 7,000 in February. And so I think part of that was probably a reflection of the press coverage of it. But, also, the plans did respond by correcting their disclosure.

DR. ENTHOVEN: Let me just butt in for a minute here. We were talking about going 'til 3:30 and then switching to the work plan. But this is

such a good discussion and so interesting and we're learning so much, I'm not sure whether to stop and leave the hour for the work plan or whether to pursue this a little longer.

How do people feel about that? Are we getting close to the end of this, or are we here to go on?

Well, maybe one of the things -- one of the things we did was to ask Helen and Ron to kind of pull this together if you have -- do you have more to say on this based on your overview of what you've heard, Helen?

DR. RODRIGUES-TRIAS: No, not really, except, I guess, to struggle through on what I think is one of our major areas of what we have to struggle through, the role of the actual regulatory agencies, not in the ex post facto regulation but at the formative stage of what's happening in managed care and in all of health care. And I -- in other words, where does the state come in in somehow forming what's out there on the basis of the best interests of the people.

DR. ENTHOVEN: If we took a kind of condemning-like quality improvement, a lot of people can reach upstream. Where are those complaints coming from and what can we do to have them never happen in first place? Ron?

MR. WILLIAMS: Yeah. I think I would

agree that one of the big issues is what is the role of government in terms of regulation of health plans. And I think the grievance and consumer protection features are very important both in terms of access, in terms of quality, which represents a whole series of licensing and certain people meeting standards.

And there's a dimension of product adequacy: Is the product providing the right kind of adequate level of benefits.

There's also a very important issue which we haven't worried much about in this state in quite a while. It's a financial solvency question, which is a very, very important question, that the consumer expects both the health plan as well as the medical group to be there when they actually do need service.

And I often talk about the financial solvency question by saying we're in excess of almost a $4 billion business. If we miscalculate by one percent, that's $40 million. And, I mean, it gives you a sense of the scope and scale of the amount of precision when you are calculating 15 months in advance how sick people will be, what kinds of technology they will need, et cetera.

So financial solvency is a very important question. I think the whole industry has been very fortunate and that it hasn't been something we've had to worry about as an industry lately.

The other things are to ensure that it is a competitive marketplace and that that marketplace is allowed to work and there is a level playing field. I think in terms of the whole grievance dimension, the term I use is validating measurement, validated measurement, but also context for that measure. Having more grievances isn't necessarily a bad thing. It may mean you are working the continuous improvement process that much harder and are really looking at the kinds of things that can help improve the level of satisfaction that your customers have.

So I think the concept of the level playing field is also something that's very important. I think the other thing, which is a role beyond the scope of this group -- I think partly what the Department of Health Services was concerned with is providing coverage for those individuals who are not fortunate enough to have access to private health insurance or to be able to purchase private insurance themselves. So one of the roles is really making certain that those dollars go as far as they can to provide as much coverage as possible.

DR. ENTHOVEN: Uh-huh. Bruce, you had your hand up.

Thank you, Ron. That was great.

DR. SPURLOCK: Actually, I think we just sort of touched on it a little bit. I think

it's a philosophical choice: Do we let this happen in the business place, or do we have government go at a lower level in regulating this complaint process or the consumer satisfaction process.

There's two different models. There's a business argument saying that it's happening already, because there's multiple studies out there that show that health plan retention goes up if you have an effective complaint process. So health plans have huge business incentive to have this complaint process be very effective up front from the business standpoint. And that actually happens quickly.

The medical model that I can see from a regulatory standpoint is similar to what we use in medicine, which is guidelines. We develop -- we don't develop hard-and-fast rules, you have to do this and this and this. We don't tell each individual doctor how they take care of each patient. We set up guidelines and parameters so the doctors can understand what the best practices are at the time. And these are flexible so that when the technology improves you can improve the care. And they're also not rigid that you can only go down this one pathway. You have the ability to make exceptions when exceptions are done.

But I think those are the two critical questions: Do we allow the marketplace to continue to do what it is, or do we come at a lower level with

a regulatory assistant point. And one possible way would use the guideline process.

DR. ENTHOVEN: That's a very interesting idea. You know, kind of relating that to Demming, Demming says, you know, abolish fear and kind of punitive approaches aren't likely to elicit quality improvement. You really have to get the positive commitment to quality improvement down on the ground at the front line, groups building up from there. That's a real challenge, to figure out how we do that here, create the right incentive.

Michael?

DR. KARPF: To follow up on that, I think that if we take a look at other industries that consumers have benefited from, it's definition of performance. If we take a look at the automobile industry, I think when people could compare through J.D. Power whatever they compare through performance --

MS. FINBERG: Consumer Reports.

DR. KARPF: Right. They have the ability --

MR. LEE: Advertising there. Watch that.

DR. KARPF: They have the ability to make some choices.

From here, I think the complaints are one element of performance. And what we need to do

is make sure that the performance report cards that get generated in fact are broader than just complaints.

DR. ENTHOVEN: Could I make a comment about the report cards? Are you all aware of HEDIS reports? You know, it's a shame that maybe somebody at DOC or someplace doesn't take them all and lay them out side by side. I just learned the other day that 95 percent of California HMO members are in CCHRI HMO's. And so like you could cover the overwhelming majority.

And there's really interesting information there, you know, retention, what percent of your members on January 1 are still with you at the end of the year, various standard measures of satisfaction and so forth. I almost felt like just getting the HEDIS report and rolling up my sleeves and putting them in a spread sheet.

MR. LEE: We would have appreciated it.

MR. KERR: The weekend is coming up.

DR. ENTHOVEN: It's just that I've got so much work in order to prepare for the next discussion. But, I mean, that could be done by someone. It wouldn't be that tough.

David, are you going to comment on that point?

MR. KNOWLES: Yeah. I've been asked here a couple of times to comment on behalf of the

Department of Insurance. And it really ties in to the spread sheet of grievances issue and Dr. Karpf's earlier request, which I intended to give some members as far as what mechanism does the department have to track complaints. And we do tabulate the types and the numbers of complaints that we receive in our consumer hotline.

But at the risk of stating a real obvious point here, in case anyone's not aware of it, we really receive a very low volume of health related complaints entirely. And it isn't just because the world is going to managed care. It isn't just because 19 million Californians now are HMO enrollees; because, historically, we have not received a high number of complaints and grievance calls as well.

And it seems to me -- I'm not sure of all the reasons why. I don't think it's because we're better regulators or the DOC are worse regulators, although we happen to believe they need a higher budget to do their job properly. But it seems to get back to the Hattie Skubik gradient on choice there. That's my best guess to tell you why we don't receive -- even with our PPO licensees, we don't receive more than a negligible-by-comparison volume of complaints and grievances.

It seems -- I'm adding interpretation at this point, but it seems to me that the degree to

which people feel that they have control by way of the choice of their plan and the type of health care they receive, they tend, for whatever reasons, in that process not to eventuate at our regulatory doorstep.

DR. KARPF: There may not be as much structure in your products so they don't identify it so the complaints end up being elsewhere in the system as opposed to at your level.

MR. KNOWLES: Well, I would tend to disagree with you on that point simply because we're averaging 3,000 calls a month that we refer to DOC.

MR. WILLIAMS: We actually have products under both entities. And I can tell you from experience that where consumers have that choice consumers simply select another doctor or go to a different activity, and they feel they have a choice. And --

MS. MURRELL: You walk with your choice.

MR. WILLIAMS: -- a consumer that has lots of choice, a physician tells them I don't think that it's time to do a procedure, they accept that. If they're in a managed care plan and that same physician tells them they don't think it's time to do the procedure, there's a different kind of concern.

DR. ENTHOVEN: Yeah. Could we just -- Keith and -- but then we're going to need to take a

break for the sake of the court reporter, if not your chairman.

MR. BISHOP: I would say one reason I would think is the indemnity insurance is a different product than managed care and that when you have a pure indemnity product, your biggest concern is for will the insurance carrier pay for it. When you get to a managed care product, it's a much more complicated thing because not only are they paying for it, but they're also taking responsibility for delivering it and for the quality of it.

So if you're under an indemnity plan and if you go to a doctor that you choose and you get a bad result and blame the doctor, you blame the hospital. You don't tend to just -- to look to the insurance company as the assurance of quality or access because that's regardless of your control.

Managed care is a totally different situation. The kinds of complaints that we get go way beyond is this a covered benefit. We get a lot of coverage, you know, questions and complaints. But we get a lot of access complaints. We get a lot of quality of care complaints, which I just don't think people would normally go to an insurance indemnity insurance carrier with. They won't expect them to be responsible for quality.

DR. ENTHOVEN: We have to bear in mind that the experience in the large groups like

Cal-PERS, University of California, where people have the broader range of choice, what's happened over the years is they've been migrating steadily to managed care. But we're concerned about managed care. Still, you know, professors at UC and people like yourselves, that's the direction, given a free choice, in which you are moving.

Bud?

DR. ALPERT: I would deal -- I know there's some public comment --

DR. ENTHOVEN: We're going to do that immediately after our break.

MS. SKUBIK: I just want to say that in my effort at brevity of getting the task force members started in talking I didn't say a lot of what needs to be said about this spectrum. And I feel that a couple of things may have gotten missed.

The most important thing is that this HMO is not the only form of managed care. Almost everybody in the State of California and nationally is in some form of managed care. The HMO is a prepaid model of managed care. There are managed care models that are regulated by the Department of Insurance that are contractually based, and they're not prepaid.

So I don't want to say managed care equals HMO. And I think it's important that we not leave this room with that understanding.

And this -- in the middle here, the key feature is that this market is hybridizing to try and take care of consumer choice issues. And we need to make sure our regulatory structure does that.

Ken?

DR. ENTHOVEN: I got to -- Kim?

MS. BELSHE': I have to leave this afternoon. I just want to make one quick summarizing comment. I think we're focusing on consumer grievance, and complaints is synonymous for the issue of quality broadly. And I think we've begun to touch upon a variety of problems in the arena of quality.

I think one of the charges for this group is really to think more systematically in terms of categorizing those issues of concern, think of it more systematically in terms of what are some of the most problematic problems in our current system. And that will then drive to the discussion, okay, where does the plan responsibility for addressing those issues of quality end and where does government's responsibility begin and where is there a joint responsibility. I think that's one of the important charges for this task force. Because it's not all government.

Ron spoke very eloquently to some of the activities they take within the plan arena. Jeanne, your question about medical groups, that's an important question for this group. Right now medical

groups really aren't regulated the same way the physicians are through the medical board or indemnity plans for Davis.

That's a good question. Where are the current gaps, how is that associated to quality problems, and what is the private sector's role; what is government's role. Once you figure that out, then you ask the question how does government organize itself to fill those gaps, to work maximally in partnership with the private sector.

DR. ENTHOVEN: Okay. For the sake of our reporter here, we're going to have to take about a five-minute break.

MR. RODGERS: I just had a quick comment. Just adding on to Kim, the other thing is what will improve the system, regulation or the market driven forces. That's the other step we have to go. Or can they be synergistic.

DR. ENTHOVEN: That or how do we make them synergistic.

(Brief recess.)

DR. ENTHOVEN: Could we call everybody back to order? There's so many vibes floating around here and so many things we want to do and so little time to do it.

During the break, Bruce Spurlock handed me this thing I just invented. I didn't realize other people had invented it beforehand, but, of

course, they have. I mean, Cal-PERS has a thing like this. But it's an attempt to portray in an understandable way, lay out side by side the comparative information that is in the HEDIS and CCHRI reports.

So there is a lot of good, useful information that is being developed, and it's just not getting published, although this is on the internet.

We will send copies of this out to members in your next packet. As I say, this information is available for PRS beneficiaries and some others. For those who can't wait, it's Healthscope DR/HP/VPrint Index, underlined, P.HTF. Got that?

MS. MURRELL: If you get on the web page for the PPGH, their report card is also.

DR. SPURLOCK: This is Healthscope.

MS. MURRELL: Okay.

DR. ENTHOVEN: So it's not as if the data don't exist. I mean, there is a lot better data we're looking for downstream. But there's a lot of useful stuff that's done.

I think what we need to do is to spend a little time offering members of the general public who have kindly come here and sat very patiently through this - but it's painful and regretful for me to do it - to ask them to be very brief because we

have to come back and get some feedback and consensus on work plan, some of our ideas of where to go.

DR. ROMERO: Mr. Chairman, if I could make a minor suggestion, Mr. Karpf has to leave, and I think he wanted to make a brief comment.

DR. KARPF: I unfortunately have to catch a plane. I just wanted to make sure that we don't slip back into a sort of nostalgic overview of choice equals indemnity and indemnity equals quality of care, but it was never measured. I think that the issue is for quality we need to measure something. Complaints is only one measurement of that.

You know, at UCLA we're an institution that feels we'll define ourselves in the marketplace by quality. We win beauty contests like U.S. News and World Report, Best in the West. But we've committed ourselves to defining ourselves. I think what this organization can do is develop a framework or help the state develop a framework of quantitatively defining so there are some measuring rods out there that the public can use.

DR. ENTHOVEN: Very good point, Doctor. Also, when you're saying that makes me think giving the patient what the patient wants is not necessarily the right thing.

DR. KARPF: Absolutely.

DR. ENTHOVEN: The patient comes in and demands an antibiotic for a viral infection --

DR. KARPF: Or a major intervention where there isn't the data, where there isn't the evidence to really support this.

DR. ENTHOVEN: Right. So giving the patient what the patient wants is not the highest standard either, which adds to the complexity.

DR. KARPF: It cuts down on the complaints, but it isn't necessarily the right thing to do.

DR. ENTHOVEN: But it could be bad for the patient's health in the case of the --

DR. KARPF: Absolutely. You are right.

DR. SPURLOCK: In the case of resistant bacteria --

DR. ENTHOVEN: Any other task?

MR. LEE: The question of process, we have from 5:30 to 7:30 for the public hearing; is that correct still?

DR. ENTHOVEN: Yeah.

MR. LEE: That's going to be open comment on a whole range of issues. What are we going to comment on right now? Is this what the earlier afternoon has been?

DR. ENTHOVEN: I hope so.

MR. LEE: I'm not suggesting that's what we limit it to. But I'm concerned we have time to talk about the work plan. So we have two hours set aside, and I'd be worried about us being short in

the time, which is already short.

DR. ROMERO: To kind of clarify on our legal obligation, Mr. Chairman, as I understand, we are obligated - and we should be obligated - to accept the public comment at all these meetings. While as a matter of preference we'd like it to be as much germane to the study session as possible, if this is your only shot, take it. But please recognize we have another very important topic to cover next which will affect the task force's operation for the rest of the year. So please try to be protective of our time also.

DR. ENTHOVEN: Dr. Shumacher, who is past president of the Medical Board of California, told me he has a comment on what we have been talking about.

DR. SHUMACHER: Thank you. I appreciate the opportunity to say a few words. I will try and be brief. Having been on the other end of sessions like this on many occasions, I know how happy the members sitting around the table are to have brief statements from the public. But I wanted to comment on several things that I heard this afternoon.

First, let me take just a moment to tell you a little bit about my background so you understand where I'm coming from as I make these comments. I am a physician. I'm a pediatrician and

a neonatologist by trade. I practiced in this community for 30 years, and I'm now in my sixth year on the medical board. I'm the immediate past president of the medical board. I'm also the vice-president of the Federation of State Medical Boards of the United States.

In addition, I spent eleven years here in San Diego County as chair of the Professional Conduct Committee, which was essentially a grievance resolution committee. So I've had a lot of years of experience in grievance resolution specifically aimed toward medical issues and quality of care issues. And I think quality of care is the first and most important thing to be considering.

Grievance resolution has a couple of more avenues that were not alluded to this morning. The medical board was alluded to only very briefly, and yet it is the main avenue in this state for resolution of grievances concerning the quality of care received by consumers all over California. It's an area in which we have considerable historical impact, experience and expertise. Other state agencies in fact rely on us for that expertise and come to us to supply that.

Another avenue of grievance resolution that's often overlooked - and that's probably because it's a spotty mechanism throughout the state - is the avenue of county medical societies and their

professional conduct committees or grievance resolution committees. The reason I say that spotty is because not every county has one. Some function far better than others. The one we had here in San Diego I liked to think was one of the most advanced and active and effective in resolving grievances.

Now, the medical board has been concerned about the quality of care in the managed care environment for a long time. We began in 1993 and early 1994 and then-president Robert Deljunco appointed a special committee to study this issue. This was called the Committee on Quality of Care in a Managed Care Environment.

One of the results of that committee was the publication in April of 1996 of a statement of concern about those issues. And I don't know if all of you have had an opportunity to see that. If you have not, I will leave copies of this or leave a copy here so that you can read this for yourself.

At the same time, we issued a statement on the nature of the physician-patient relationship, which is an important component in the delivery of quality of care. There was also some testimony that I had the pleasure of giving before a Department of Corporation hearing in January when they were dealing with the Pacificare and Foundation Health Care merger. And I will leave copies of all of those statements with you to give you an idea of the

medical board's concern and position statements, which are very clearly laid out for you. Because we are concerned about the quality of care.

Lastly, I'd just like to make some comments on regulation. And I'd like to make those not as a member of any of the organizations that I have named but as a private citizen. So with that disclaimer firmly in all of your ears, I will tell you that the chart that you saw this morning is, I think, a great illustration of how fragmented the system is for dealing with the regulation of managed care.

I heard the question asked not long ago about medical groups and how they're regulated. The answer is they're not, basically. There's almost no regulation.

Now, the job of the medical board is to regulate individual physicians. And that's what we do. That was, in fact, set up at a time when most practices were individual practices. The medical board goes back over a hundred years. Practices were individual. There were very few medical groups as such. And certainly the idea of managed care was one that was looked on with great horror by most of the medical profession until fairly recent times.

The regulation of something as complex and something that is in as much flux as managed care -- and it is in flux. I don't pretend to know where

it's going to be two years from now. I don't know. I don't think anybody knows. I don't think anybody can even make a great guess. It's in major flux.

And I would just urge you in your deliberations to remember that there are two departments that historically and currently have the expertise and the experience to deal with quality of care issues. And that's the medical board and other associated departments in the Department of Consumer Affairs and other Department of Health Services. That expertise does not reside in the Department of Insurance or the Department of Corporations, which were set up as agencies within government to do entirely different things and, consequently, do not have the base to deal with what now has become a markedly changed climate.

So I say that to you to hopefully be of some help to you in your deliberations. Before I leave, I will leave copies of these statements that we have here with you. And I appreciate the time that you've given me.

DR. ENTHOVEN: Thank you, Doctor.

Are there others members of the public who want to make statements now? I'd appreciate it if they are brief, if we could -- yes, sir. Do you want to introduce yourself?

DR. FELLMETH: I'm Professor Robert Fellmeth, Director of the Center of Public Interest

Law. I just have a few comments, if I might, just for three minutes, two minutes.

DR. ROMERO: Sorry. Professor, just for information for you, I don't know if you were here at the time, but there was a brief discussion of your memo that was in the members' meeting packet earlier today. So you won't need to reiterate that.

DR. ENTHOVEN: We've read your excellent letter.

DR. FELLMETH: I would like to make just a couple of quick points for you. We've been watching agencies here in California for 20 years now, and it's been published in the California Reporter. We've had different kind of meetings systems and arrangements to see what works and what doesn't help, what has the confidence of the people.

Now, we commend you to avoid the kind of structure the Department of Insurance has had for many years historically, which has proven to be a disaster. And all you have to look at and see what kinds of problems have occurred in the Department of Insurance in terms of regulation, a single actor who has to look at thousands of consumer complaints coming in and ends up kind of trying to mediate them without ever disciplining anybody. It really ends up being quite a nightmare. It has not worked and won't work.

I urge you to have a system where you

have a public body, a board, like the medical board or any one of the number of boards we have, where you have the opportunity for meetings and public input, as I mentioned in my letter.

I would also advise you to put this body someplace where there is expertise. Yes, the issue of solvency is going to be important. It's going to be there. But it's going to be overwhelmed by the issue of care, quality of care and the denial of care. Because we had an incentive for many years of pay by procedure. And we had too many procedures. We had excessive costs.

Now we're erring in the opposite direction. We're going to capitate up front. We're going to make money based on how much they do not spend. We don't seem to come up with a system that's down the middle.

There is a possible system down the middle, but we haven't done it. So now we're going to have denial of care, and we're going to have fights there. And there's going to be a plethora of complaints coming in. There's going to be pressure. You'd better have a knowledgeable representative there. I had my day in front of the agency. Because otherwise you're going to get a Prop 103 here very quickly.

MR. LEE: Can you say some -- when you say avoid the DOI structure, what are the elements of

the DOI structure that you find particularly problematic? What do you mean by that?

DR. FELLMETH: First of all, a single person making a decision behind the desk with no ex parte contact is prohibitive. There will be no public confidence in a system which disciplined in a period of 40 years one insurance firm. One in 40 years. That's not the kind of system you want, and you can't have that kind of system because it's going to lead to a very, very strong consumer response.

You want a system where there's going to be legitimacy, there's some confidence, there's some expertise. Leaving it over in Corporations, that's crazy. That's just crazy. You could put it in DCA. You can justify that. You could put it in DHS and justify that. You can't justify putting it in Corporations. It's silly.

You go back to 1984, there was a hearing in 1984 about the silliness, about changing the Department of Insurance and Department of Corporations. It was 13 years ago. We should have learned by now that some things work and some things don't work. It doesn't work to put things stand-alone where you've got three other agencies in the same subject matter area. Let's have some skill. Let's have some expertise.

We worked very hard to work on the form, as Dr. Shumacher knows, to get expertise and

independence. It's the combination which is critical here. You've got to have someone who's independent, who is not going to go to the industry the second they leave and who doesn't come from the industry and who knows the industry but has that independence.

Medical board, we've been able to go to the DA's office to prosecute medical complaints. We have a separate unit of ALJ's that hear medical cases. They have expertise and independence combined. You need to go in that direction here too.

DR. ROMERO: I'd like to ask one more question.

DR. ENTHOVEN: Go ahead.

DR. ROMERO: Well, a two-part follow-up question. First, independent from whom? By which you mean it is important that that board's members be individually elected, or can they be appointed by, say, the governor or some other elected official?

DR. FELLMETH: I don't think being individually elected is a panacea for anything. Then you have dependency on campaign contributions. I don't have any problem with appointments. I just think they ought to be public members. They ought not to be appointed from the industry billing to the industry.

DR. ROMERO: The second portion of my question -- I think I know your answer, and I'd like to hear the rationale behind it. I've heard an

argument that goes, you know, there are the open process, due process, advantages of boards as you just described. You know, there are disadvantages of board policies and cumbersomeness. What about an approach like an advisory board to avoid an appointed regulator? You know, does that have the worst of both models or the best of both models, in your view?

DR. FELLMETH: It is not the worst of all models. It is a mitigation of the better model where the board makes the decision. When the board makes the decision, you have the legitimacy of the group making the decision getting the input in a fair kind of manner. If you have the private individual, again, with ex parte contacts going on, advised by a body, it can be looked upon as a shill group. It can be looked upon as window dressing.

That's been tried. The Department of Insurance tried that. They set up an advisory committee group, didn't like what it was doing and abolished it. That's something that's going to cause you more trouble, I think, than it's worth.

It's better to do it right from the outset and have the pain of public meetings, as you're having here. And you're doing it. Why shouldn't the group you set up do what you do?

DR. ENTHOVEN: I have a question, which is thinking here of the dispute resolution aspect of it. Is this process appropriate for the executive

branch? I mean, you talked about independence, and I think, well, should this be some kind of, you know, quasi-judiciary, somewhat freestanding entity.

DR. FELLMETH: That's a very good question because that's something that scholars have been debating for a long time: Is it fair to have a disciplinary system in the executive branch where administrative law judges make the decisions and then it goes to the judiciary later; is it a fair decision when the agency doing the prosecuting is also making a decision through its ALJ.

As I understand that issue, my answer to that is that's why we have an Office of Administrative Hearings that's independent. It should be more independent but who is independent from the agencies. And we have created a ALJ panel of medical specialists. It's sitting there waiting for business.

DR. ROMERO: An OAH?

DR. FELLMETH: There's an independent group. Let's use that.

DR. ROMERO: Where is that panel?

DR. FELLMETH: It's in the Office of Administrative Hearings. They are sitting there. That's all they do is handle medical matters. We spent four years trying to get the legislature to do it. They did it. It's eight or nine ALJ's who do nothing but medical matters. They have expertise and

independence, the combination that you're looking for.

DR. NORTHWAY: Where do they sit?

DR. FELLMETH: They sit in the Office of Administrative Hearings as administrative law judges who hear cases, discipline cases, and they --

MS. BOWNE: Could anybody find that on the chart?

DR. ROMERO: I'm looking for it now.

DR. ENTHOVEN: I'm glad I've got your phone number.

DR. FELLMETH: It's in the Department of General Services.

DR. ENTHOVEN: Thank you.

MR. LEE: What sort of cases route up to them?

DR. FELLMETH: Well, any discipline case or any adjudication by an agency. Any accusation that is made by an agency against a licensee would go to that entity for hearing and trial, if you will.

MR. LEE: So one of those eight or nine are one of the folks that heard the Christy case?

DR. FELLMETH: Exactly.

MR. LEE: And have any other cases from DOC ever hit that level besides the Christy case? How many?

DR. FELLMETH: A small number, I'd say.

MR. LEE: So if there's eight or nine people hearing cases -- I'm sorry.

MR. BISHOP: Well, the number, for example, the 800 number, we took action against 80 plans. I think twelve of those plans have requested a hearing. And should they pursue their request for a hearing, that will be heard by an administrative law judge. We have de -- I know we have an administrative proceeding with Delta Dental. That was heard by an administrative law judge.

DR. ENTHOVEN: Well, Professor Fellmeth, do you think it's -- just on the question -- we need to consider both the fairness -- the reality of the fairness first is the most important thing and also the perception of fairness and also the economy of the whole thing. You know, we hear horror stories about how in malpractice litigation that two-thirds of the money goes to lawyers.

DR. FELLMETH: Uh-huh.

DR. ENTHOVEN: And, you know, so we need to have an efficient, expeditious --

DR. FELLMETH: Right. Now, you have the Department of Corporations ALJ straight from this unit duplicating what they're doing without the same kind of background. Let's go to the ALJ's who are in power. Let's use the people who are there. They have independence. They have credibility. Let's use them.

DR. ENTHOVEN: And that's independent enough?

DR. FELLMETH: That's independent. It's the Office of Administrative Hearings. It's not under any of the agencies that are involved here. It's a separate entity directly from the governor's office on down.

DR. ROMERO: Just for the purposes of state speak orientation, those of you who have your chart, if you look at the highlighted boxes, if you look at the lower right highlighted boxes, you see the Department of Consumer Affairs. They are one department within a larger agency called the State Consumer Services Agency. Office of Administrative Hearings is two boxes directly below it within the Department of General Services.

DR. NORTHWAY: What about this thing up above it that says Office of Administrative Law?

DR. ROMERO: It's not the same thing. If you're interested, I'll tell you about it, but it's a separate organization.

DR. NORTHWAY: No, I'm not interested.

DR. ROMERO: You're a wise man.

MR. SHAPIRO: Mr. Fellmeth, I know that you sent the memo to Senator Rosenthal. One of the variations we're looking at - maybe you can comment if you're familiar - is the Air Resources structure, which has an independent board, but it's a part-time

board. It has a very strong chair, a full-time chair. It has a very strong executive director to execute the law, the regulations, but the policy and the rule making on a limited basis is done by an expert board who have other lives. They're doctors. They're engineers. They're other folks who bring expertise. But they have to deliberate in public with the chair, who's essentially an appointee of the governor. This is a model that we're looking at which gives you a strong executive leader who can execute the laws sufficiently but an accountable, independent board --

MR. FELLMETH: Just be careful about conflicts with the board. I mean, you want independence and expertise. And it's hard to combine the two. That's the dilemma here. It's very easy to go to the industry and say you people decide and then recuse yourself if you have a direct conflict. But the problem is not I'm going to make money. The problem is I'm in a tribe, and my tribe's going to make money. It's the tribal rules that I worry about. I go to the Bar and see what they do, and it's the same problem.

DR. ENTHOVEN: Thank you very much. I'm going to sort of bring us back to focus on -- could we hear from you at 5:30? I apologize, but I just realized that we're just running so far out of time here.

Okay. Work plan. I'll just quickly say a few things. I think what we'll want to do is carry on some continuing interaction with the task force on this. We may come up with a new outline, fax it out to you, ask for comments and feed it back two or three times.

At this point we want to get some sense of priorities from you. Let me just mention a couple of things that we are talking about. One is, of course, as we do this we must carry out the legislative mandate. So there will be reports written pursuant to the issues in the Richter bill. And sometime downstream, as the reports become ready in draft, we will want to be sending them to you for comment, suggestions, additions, et cetera. And so we'll go through sort of an iterative process with that.

The other thing we've been exploring is the idea of creating something -- and we had to be very careful about what we called it because of the Open Meetings Act and everything else -- what we might call expert resource groups.

There are a number of people here who have particular expertise and interest, and we were thinking of calling on some of them to kind of work in little, small working groups. And we may be able to support that with some of our staff people who would focus on particular issues and help us to

perhaps kind of draft a suggested analysis and description, state-of-the-issue and the like.

For example, on physician -- or provider incentives and the effect on the patient-provider relationship, we were thinking, for example, Dr. Conom, we might ask you if you would -- we'll get back to you to --

DR. CONOM: Sure.

DR. ENTHOVEN: For example, we might ask you and Steve Zatkin to work together.

Or another one is streamlining the administrative burden. I really hope we can come up with some good suggestions for how to ease the burden of the multiple reporting and to sort of -- and Kay Murrell indicated she would be happy to work on that. And her connection with PGH that she's been working on, that could be very helpful.

On the dispute resolution process, Peter Lee, for example, has done a lot of work on that. On consumer information, formalizing consumer involvement, Ellen -- where did Ellen go?

Ellen, we were thinking we might ask you if you could collect thoughts and start writing them, and then we can cycle them through the task force.

And so we'll want to follow up with each of you that I've mentioned and with some others about --

MS. BOWNE: Excuse me. Who was on provider incentives?

DR. ENTHOVEN: Well, others would be very welcome. But I was thinking of starting with Dr. Conom and Steve Zatkin, two people we think of as concerned and knowledgeable and -- but there may be others. So we're thinking we might put together a sketch of that and fax it out to you and then ask for your comments if we suggest you might be on this or that one. And you can circle your name here or say no, I don't want to be involved, or here's a piece that I would particularly like to work on. We really need to find a way to harness the expertise of the task force.

The legal advice that we've gotten, as long as we are very careful that as long as we don't call it a subcommittee, that we make it very, very clear that this is not a decision making body, no decisions will be made in these -- what?

(Brief pause.)

DR. ENTHOVEN: Oh, it will have to comply? That's our latest -- oh, you mean if three -- oh, God.

MS. SKUBIK: They have to be publicly noticed.

DR. ROMERO: Just a brief comment. And this comes up over and over. I speak for myself, and I think I speak for Alain. The public notice and the

public participation is highly desirable, but it's administratively a pain in neck. And with a small staff, all of which you see here, it's a major burden.

So we've been trying to design these groups so that we can divide up the group and provide us useful resources without adding additional burden.

MS. BOWNE: Sounds like you will only have two.

DR. ENTHOVEN: We may have pairs of people. It's no desire to keep out public involvement. It's just that if you have to set this up with a ten-day notice, there's secretarial work. It's the inconvenience.

MS. SEVERONI: Maybe we can use pairs of people.

MS. SKUBIK: One model that I have been toying with and was planning to write a letter but haven't gotten around to is would it be possible to think of these work groups, expert resource groups, to also include particular experts who aren't necessarily on the task force but also have a high level of expertise on a particular matter, for instance, Professor Fellmeth, so that they would be called -- they're not subcommittees. They're resource groups to work on such issues as the task before us on academic medical centers and the effect of medical education on managed care.

DR. ENTHOVEN: We'll have staff writing paperwork, but we want to make it interactive and tie it in with those of you who have particular areas of knowledge and expertise. Let us know if there are particular areas that you would like too.

Peter, I apologize. I didn't try this out on you during the break.

MR. LEE: I've been not available. I've been not around the last couple weeks. That's okay. But I'd be willing to --

DR. ENTHOVEN: Yeah. Sort of help open, conceptualize, work with our staff person to talk about how this might look and, yes, draw in other expertise, like Professor Fellmeth and others, you know, get different models and states of the issue.

So that's something we hope to try to move forward on. And let us know if there are particular areas that -- oh, another one is managed care, the impact of managed care on vulnerable populations. Helen would be interested in that.

MS. RODRIGUES-TRIAS: Uh-huh.

DR. ENTHOVEN: There is a research literature on that.

MS. SINGER: We have the resources at Stanford to run literature searches. I don't know -- have we run one on that role, something not specifically, but some things related to that have

come up.

DR. ENTHOVEN: We can run that on Medline and get a list of the articles on that. So that's one thing we have in mind.

And the other thing is to talk about scope of work. Phil, do you wanted to --

DR. ROMERO: Sure. Let me take over. In order to -- the first part of the study session was an experiment, I hope - I think - a successful experiment. What we want to try -- what Alan and I have been talking about doing is scheduling future study sessions and most meetings, meetings up until near the end of the process where formal decisions need to be made, to educate the task force and to get their input on specific topics.

The first experiment earlier this afternoon, the topic was, in essence, should there be changes in the way the state organizes its regulation of health care plans.

Two reasons for doing this. One is a very, very powerful group here, and we want to make sure -- we want you to work on the most important thing by your definition.

Second is, if you know what topics are going to be discussed at which meetings, you can plan your schedule accordingly. If you're not able to be at all of them, you can be at those meetings that you find personally of greatest importance.

So the staff took a cut -- actually, took two cuts at menus -- a menu of meeting topics. And they were distributed -- well, sorry. One was distributed as agenda item 3B in your packet that you got about ten days ago and which I've summarized here. I'll talk about this for a moment first, and then I will talk about April 2nd -- a second organizing principle that we've identified as well. And, again, I refer to your handout for more detail.

But this is just an attempt to take the various good ideas we've heard and group them topically so that we could identify needy topics that could be the focus of future individual task force meetings or study sessions.

And my apologies. This is about as large as I could write in the space. For those of you who can't read at a distance, the first is advancing consumer protection. The second is the ideal regulatory organization, which, in essence, we started on just earlier today. The third is improving quality of care, which I think would include a lot of information strategies that we touched on today. The fourth and fifth are both choice related. The first is increasing choice among plans, trying to assure that more enrollees have more choices.

And, again, the -- I hate to borrow from the master, but I am aware from Alain about just

how much choice I as a member of PERS have available to me, and that is, in essence, my glimmer, trying to make that available to as many non-PERS members as possible.

The fifth is increasing choice within plans. We go back to Hattie's spectrum of choice she referred to. The notion is even within plans trying to allow the individual enrollee the choice of going outside of the network if they are willing to pay the cost.

And the sixth is industry restructuring. And I mean the industry that Hattie referred to in her remarks for the policy development effort and, for that matter, does this task force have an opinion about the perspective future restructuring the industry will be undertaking.

And I'm talking like a corporate strategist, which is my former occupation, but what I mean by that is primarily the consolidation of plans, ownership, the increasing share of plan enrollees that are either for-profit as opposed to nonprofit plans, and, finally, the vertical integration plan that Hattie was referring to earlier and this shifting of risk from plans to providers primarily through medical groups under all their various names.

This is just a menu. This was staff's attempt to cut at -- to try to summarize a number of things under a few topical baskets. Now, I will

mention that this was not to try to exclusively limit the format of the Richter bill, although, in our opinion, we think that we captured the Richter bill's description with the details.

There is an alternative which I think was passed out called Scope of Work Details that more explicitly and appropriately mimics the Richter bill format. That's it.

My objective here is twofold. First, I'd like to know what you'd like to add to this list, and then, second, I'd like to capture your priorities among this list so that priorities among this list and therefore -- so that the staff can develop a proposed schedule for your review at a future meeting of schedule, whereas individual topics are covered in individual meetings.

So with that I'll just stop and invite Hattie to also answer questions, if you have any, about the substance of this. If there are other topics you'd like to add that are not captured in these categories, I'd like to invite those additions.

Ron?

MR. WILLIAMS: There's one issue which I often think of as a counter-intended consequence, which is, in terms of trying to increase consumer protection, improve the regulatory environment, accomplish many things that are highly desirable, we also have the potential to increase the number of

uninsured. We do that by increasing costs and pushing people out of the insurance pool because employers on the fence end up opting not to insure, not to purchase insurance.

So I think somehow or another that's a topic we just need to be sensitive to as we look at a list of, you know, very good issues and topics, I think, to work on. There is this counter-intended consequence that we need to be sensitive to.

DR. ROMERO: Let me try to replay that back to you just the way I would think of this see if you think that is a fair reflection. You know, any policy recommendations that we make or tiptoe up to the edge of, if we don't make them, we'll be making based on some set of criteria, some sense of the impact of those recommendations. You've just mentioned one important impact, which is a hard-core employer might say what effect will this cost have on my costs and my ability to offer insurance to my employees. We've heard about that from several small business people.

You're saying it a different way, which is, and therefore, if they don't offer it to their employees, some of those employees will be without insurance, reducing insurance aspect. Thanks.

If we think of that as a -- if we think of that as one of a number of criteria, the criteria is that --

MR. WILLIAMS: Yeah.

DR. ROMERO: Okay. I'll just make a running list of criteria or impacts that we need to be sensitive to, and one of them is basically increases or decreases --

MS. SKUBIK: And that would fall under 4C on the scope of details under spillover of health costs. That would be an important thing to keep in mind.

DR. RODRIGUES-TRIAS: I'd like to rephrase it, though, a little bit differently, though, because it's not so much --

DR. ROMERO: This same one, Helen?

DR. RODRIGUES-TRIAS: Yes. There is a concern about the negative effects. And that's real. But where is our proactive stance on increasing the effectiveness of managed care by increasing coverage?

And I think that was a major issue when we discussed it in terms of in terms of the small purchasers or employers who, you know, are out of the market literally and how do we enhance, you know, that ability to purchase.

And I think there are a number of issues in terms of, you know, basic packages that should be offered that increase coverage for children. I mean, there are a number of measures that can be taken that actually increase coverage. So we should look at that.

DR. ROMERO: So just, again, to see if I'm understanding you properly, it would be somehow or another encouraging and to somehow or another hides an enormous partisan from a philosophical decision but now --

DR. RODRIGUES-TRIAS: The growth into the vast -- into the millions of uninsured that we have in this state so that we begin to see as a goal -- five years down the line or whatever seems to be a reasonable timetable that we're going to have fairly full coverage.

DR. ROMERO: I call this encouraging new products that in essence are availed of by some of the currently uninsured. Does that capture your idea?

MS. SKUBIK: Or maybe even different market structure, some of the things we've been talking about, for instance, making purchasing cooperatives available somehow to individuals to make that market more accessible --

DR. RODRIGUES-TRIAS: Exactly.

MS. SKUBIK: -- to people who don't have others to make it more affordable to them.

MR. SHAPIRO: Can I issue a strong caution on this, given the mandate, that the political dynamic in the legislature is that every time there is an effort by the legislature to improve quality of care, enhance something to increase

choice, the immediate response on the part of the industry is it's going to increase costs and you're going to have unintended consequences of reducing the population of those who are covered by insurance.

The answer in the legislature is there's an enormous number of bills that have nothing to do with managed care that have to do with Kennedy-Kastlebaum. That have to do with small group reform, mid-size reform, mid-size coverage, tobacco tax subsidies.

I'm concerned that if the group gets on a defensive posture of any proposed quality dynamic in the managed care field it elicits this well-defensive reaction that I'm increasing costs without at least understanding there's a whole literal task force associated with welfare reform and others that are looking at the issue of covering the uninsured but not at the expense of a second class medical system in managed care but to improve managed care and at the same time deal concurrently with access to care by those who are not covered.

So I just caution you that recommendations that are -- where you trim your sails on quality improvement and consumer protection because you are fearful of reducing the coverage of the population may not be recognition of the concurrent efforts to increase access without a trade-off.

DR. ROMERO: Now, I'm not -- you could mean one of two things by that. One is that there are -- some of the things that we are listing or could list are out of our scope because somebody else is doing it, or the other is that if we address this issue we have to be mindful of the fact that there will be a defensive reaction on the part of one agency or another.

MR. SHAPIRO: I think if you're going to address it you can't ignore what's happening to respond to those issues outside the scope of an ideal managed care environment where you promote competition but you seek all those goals that you've listed there and you try not to worry too much as an initial matter of the cost consequences if that's simply a factor of uninsured, if you're dealing with that in other ways that have nothing to do with managed care subsidies.

DR. ENTHOVEN: There are going to be others reasons for cost consciousness, including the cost burden on employees and the business climate in California, et cetera, et cetera, you know. So --

MR. SHAPIRO: Absolutely. I'm not suggesting that that's going to be considered but --

DR. ENTHOVEN: But that's just one reason.

DR. ALPERT: It seems to me what you're doing now is listing what could be listed under a

large rubric of simply an analytical test of whatever the policy is. You come up with examples, and you test it and so on: Are more people going to be covered under the system, are less people going to be covered under the system, is cost going to go up.

Some of the reasons we're here is, again -- not to beat a dead horse, but the next legislative thing to come down the pike will be if indeed there will be a move to legislatively create to prevent companies discriminating against people for genetic profiles. That's something in the future. You could predict that. That would be consistent with legislation that we have now. Is the system we create -- yes or no, will that somehow mitigate against that. The answer should be yes. The answer is that it should not get to the legislative position.

So you try to ask questions, try to shoot down our hypotheses and have a session where maybe we can get some questions that everybody submits and have as many as you want to test the hypothesis.

DR. ROMERO: Well, let me just make a comment about sort of the issue alluded to by folks in the last few comments. It's the whole issue of how do we address and reflect, you know, the moving train of legislation and other policy activity going on in other places.

I interpret the legislation and the charge from the governor to mean we're supposed to think fairly macro, big picture, and not -- and therefore not be reactive to individual -- you know, individual proposals, with one exception that we've gone over before.

On the other hand, if we take that -- what I just said literally, we become irrelevant. So that dynamic tension is something very much on my mind. I don't have a bottom line on this. I just want to let you know that we are constantly walking a line of trying to make sure that this task force thinks big enough to make macro structural recommendations yet not so big that it's so abstract and not relevant.

DR. ALPERT: All I'm saying is that you have a session where if you stepped up to the plate and made a recommendation, we then as a group test our recommendation against the many things that have been brought up that may be the law of unintended consequences, which was what Ron was saying.

MS. SKUBIK: So what you're saying is that when we come up with what we think would be the best system we can come up with, we might then say we believe that this might increase costs by 15 percent, what would be the outcomes of that and what might -- how do we analyze that.

DR. ALPERT: I'll give you an example.

At the Medical Board of California we were charged with changing the entire way licensure was done for all physicians in the state. And we're in the middle of that now. We've come up with a whole system to eliminate an oral exam that's been here forever, substitute a whole exam coming from elsewhere.

When we came up with this, we then tried to shoot it down. We said, well, what about the physician that graduates from here and does his training here and so forth; does that fall through the cracks. And when you exhaust your possibilities, if the system you come up with handles them all, then you have a good system.

DR. ENTHOVEN: Bruce?

DR. SPURLOCK: I just wanted to make one point sort of underlying what we're doing in our work. And it goes a little bit to what we're talking about. But my bottom line is answering the question will care be better after our task force gets together and makes recommendations.

And I think that in medicine when we do things, we have a lot of confidence it will get better or a little bit of confidence, or we don't know but we think we're going to do it this way anyway because this makes the most sense. I think the task force needs to use that criteria. We have a high confidence, a moderate level, or we're not really sure about it but we think it makes sense.

Because I think that guides what happens afterwards, and I think that makes us more sure about what we're doing when we say this is going to be a good thing and we go up with the analytical process and we think --

DR. ALPERT: But the things may be unknown

DR. SPURLOCK: That's right.

DR. ALPERT: You might not know. But everybody else is going to analyze it later so we're going to hear about it. So we might as well anticipate it.

MS. SEVERONI: We shouldn't be afraid of the minority opinions.

DR. ENTHOVEN: That's right.

MR. RODGERS: Could we also look at who pays the bills, driving health care costs up, who pays the bill, the employer, government, et cetera, as one of the aspects we look at?

DR. ROMERO: I'm going to have to ask you to repeat that.

MS. MURRELL: Who pays the bill.

MR. RODGERS: Who pays the bill, not just the cost as just a criteria or an impact. It may hang out there for a while. I don't know. But --

DR. ENTHOVEN: Yes, Ellen?

MS. SEVERONI: Also, I guess sort of

following along your statement there, Tony, because I do think the consumer -- we're always paying the bill. It's just sort of hidden.

DR. ROMERO: Whether as taxpayers or directly, we're always paying the bill.

MS. SEVERONI: But along those lines, I look at the very first topic, which is enhancing consumer protection. I tell you that I always cringe a little bit because I think the focus on enhancing consumer protection implies in there that somehow we need to be protected and that we have a passive role in all of this, that -- and I think that in the end I will always be the best protector of myself and of my family's health care.

So it seems critical for me that we look at some topics or at least at one point look at a topic that has to do with consumer involvement.

MS. MURRELL: And responsibility.

MS. SEVERONI: There are some models in this state already that I think are pretty effective. We've got some member advisory committees in place. I'd like to hear more about how those bodies are helping to organize the way plan activities are run. I'd like to know more about a variety of advisory committees and even projects that organizations like mine are working on that are driving improvements in quality by bringing consumers right to the decision making table as the decisions are made in plans and

with medical groups.

And I think part of our task is to really look at where we would like to shine a light on those kinds of activities and hopefully look for some incentives that would encourage people like Ron and others in plans to be more open about bringing those kinds of very active structures into the delivery of health care.

DR. ROMERO: Let me just make a deliberately provocative comment about that. I don't know where my personal views on are on this. This is just a mirror of what I've heard. I've been making the rounds talking to several legislative leaders in both parties to let them know about the task force and get there input. Several of them, both Democrats and Republicans, have made, in essence, a strong argument for MSA. Sometimes they've used those words; sometimes they haven't.

In other words, if it's the consumer's money, they'll take responsibility for the decision. I don't think you mean something that strong. But the point I want to make is --

MS. SEVERONI: Well, watch out, because you don't know where I stand. I'm not suggesting that here, but I happen to think that in the end that's probably one of the ways business --

DR. ROMERO: It's not my money so I never will give it quite the same importance. The

upshot is that we are hearing from both sides of the aisle some view, you know, strong resonance, about this theme, they're being a little bit premature on their recommendations of how to deal with it, but I'm hearing a lot of legislative interest on that topic.

MS. FINBERG: I'm going to have to go so I wanted to say in terms of priorities of those topics, from my point of view -- and I'll really resist the temptation of talking about MSA's because I have very strong views that are quite contrary to yours.

DR. ROMERO: I don't know what mine are.

MS. FINBERG: But my priorities for the task force are really the enhancing consumer protection and improving quality of care.

DR. ROMERO: Okay.

MS. FINBERG: So I wanted to -- and I hope that we can give a lot of time both for information collection, discussion and reporting on those topics.

MS. SKUBIK: Since you're about to leave, one of the things that we're hoping to do with this list is sort of link these up with meeting topics. And just as a sort of think piece, we're sort of thinking about doing the quality and information piece at our next meeting. And maybe I

am interrupting. I'm sorry, Phil, but --

DR. ROMERO: I was going to make the same point.

MS. SKUBIK: If you have recommendations --

DR. ROMERO: We've been advised to include the quality topic in the Fresno meeting, which is the next meeting on June 20. I'll put it out there because if anyone disagrees and thinks something else is more important, I'd like to hear about it.

DR. SPURLOCK: Can you do quality in one meeting?

DR. ENTHOVEN: Well, there's that, and there's also the problem of whether we can have the materials ready. But we'll see. We might.

DR. ROMERO: Well, one more moment on other topics, and then the next thing I'll turn to is interest in following up on Jeanne's priorities. Peter?

MR. LEE: I noted in your earlier notes about who might do background papers you already alluded to what I think is one of the cross issues, which is criteria of impacts on vulnerable populations. I think, again, it's not a separate meeting, but it's one of the measuring sticks that we look at all of these.

DR. ROMERO: Thank you. Yes.

MR. LEE: The other -- this is a point -- since we have sort of these two different work scopes, I do much prefer the one up there was a one we talked about for priority settings. It frames discussions much better. But within it, one of the -- the area three we have for quality of care, all of these issues are about improving quality of care.

And, really, as I read the subtopics, under the heading quality of care, what it seems to be saying - and I want to see if I'm reading it the same way other people are - is improving information and selection and dissemination of data about quality of care. Most of the points there are about what data is being collected to assess or monitor how care is being provided and how effective is that data.

If we're trying to get other things about quality of care, the data collection, education, sharing, let's flesh those out in other places, maybe, or be more clear about what that topic means.

DR. ROMERO: I'm not a longtime health person so I don't have the secret handshake and actual the jargon down. But in the discussions about quality of care strategies that I've heard, both in public hearings and discussions of individual task force members, I'd say 50 percent of them have been about information gathering, formatting, dissemination.

MR. LEE: I think that's right, but I just -- framing that's what this topic --

DR. ROMERO: Yeah, that was not to make a decision for you. That was simply to note that that is my current understanding unless the task force advises different.

DR. ENTHOVEN: Well, on 3A we have kind of a legislative mandate to have a finding on. And what I'm thinking at this point is there is a certain amount of research literature on that. I'm thinking of articles my Luft and Miller that have researched the -- and generally what they say as the sense of the research -- the consensus of the research literature is that the quality of care in managed care is as good or better than in fee-for-service.

So we can lay that question out, and the paper might just say, well, that's what these researchers find. The task force might want to -- might or might not want to state a finding on that and say, okay, we are persuaded by Luft, Miller and all these other authorities or we're not.

MR. LEE: Well, I think that the one exception in that list is 3A.

DR. ENTHOVEN: Right.

MR. LEE: And 3A has at least three things going on: Impact on managed care and patient relationship, which may be distinguished from the care being delivered. And I would say the impacts on

the patient relationship would be one of the criteria issues that we should be looking at across the board, whether it's about the grievance process, how do you encourage and foster the patient relationship or whether it's about quality data. So I'm not quite sure where that one falls out for me.

And one other question that I --

DR. ENTHOVEN: Yeah.

MR. LEE: One other thing we've had a lot of charge for us to do is how do we take this to make substantive recommendations about organization of government. And this doesn't track very well to the organization of government. And by that I don't mean the various boxes on the huge chart. I mean the functions of accreditation-type functions of approving a provider, whether it's an individual or a group; the monitoring processes, whether it's auditing or ongoing; and the grievance-type functions.

And those sort of cut across different levels here. And that's an observation I don't quite know how to address. But this doesn't dovetail directly with how to organize the government.

DR. ENTHOVEN: It makes it hard to figure out how to write the papers.

DR. SPURLOCK: I would say that's a piece of why I would say that just doing information and finding out information, doing 90 percent of our

quality work in information, is going to miss the boat. Information is one thing, but information does not guarantee or improve government.

And taking it to the next state, what do you use with that information. How does that information feedback into a quality improvement process is as critical as studying valid information.

So I am think we should study that as one component of how you feed back information into that. I think that's why you just can't box it in to information.

MR. LEE: In response, I think the whole issue about information is what are the sources, how valid is it, and who is it used by. That's where the -- is it used by purchasers? Is it used by regulators. Is it used by individuals? To that extent? That's where you get some of the feedback into how the information is collected, how valid is it, how is it used.

MR. WILLIAMS: I think there might be an opportunity in terms of sources of information on this to bring in someone like PBGH. Perhaps the Association of Health Plans could provide staff to explain what do health plans do to measure quality.

And there are very substantial initiatives under way, many of which are industry consortiums, that could give you a sense of what are the practices. I think people would be both

surprised and pleased at the level of resource that people are permitted. But I think it would provide a fact base.

MS. MURRELL: And how long it has been going on.

MR. WILLIAMS: And I think also the very important goal that purchasers have been playing in helping to bring the industry together. So I think that could provide a fact base as to what is actually going on.

I think some of the leading clinicians in this can also point out the limitations of some of the information in terms of what it means and how difficult it is to accomplish some of the kinds of outcome-based studies that people talk about that really represent significant challenge.

DR. ALPERT: One thing that was apparent to me is the lack of information amongst everybody here who come from different backgrounds. I know how some of the existing regulatory aspects of the government work now, and none more apparent to me today as after the presentation of the gentleman from the Center for Public Interest Law. He was essentially alluding to the Medical Board of California, which structure of I assumed everybody knew. But the boxes which are provided to us which are a large framework don't get into those things.

So possibly you could disseminate, take

a few of the other regulatory agencies and disseminate information to everybody here that they could see exactly now how it exists. For instance, with the comment that was made earlier, the medical board, half of the members are public members, are consumers. They are at the table. There was an article in the Orange County newspaper a few weeks ago. I had to laugh. It was very critical of the medical board. And the criticism was it was based upon a bunch doctors, whatever, the fox watching the hen house kind of thing. And the whole gist of the article was to get public members onto the -- members from the public on the medical board.

Well, the member board is made up of half public members. The current president happens to be an attorney from Los Angeles.

The system works wonderfully, and it occurred to me that some people may not be aware of the existence of regulatory structures that somehow may help us come up with the model that we have. That's just a question of information.

MS. SKUBIK: In that first picture handout that we gave about the vertical and horizontal integration in the industry, the question is then, you know, how much of the vertical and horizontal structure do we want to do at the regulatory level.

And we may want to shift things.

Because if you've got the medical board here under this consumer affairs and there's a level of expertise that could be very helpful, say, combined with what's going on at the Department of Corporations, you know, maybe there are some natural marriages that we should be considering.

DR. ALPERT: You mean as an evolution from where it is now?

MS. SKUBIK: Yeah.

DR. ROMERO: In the interests of the clock, I'd like to now shift to priorities. And I had actually, as Alain suggested, had a different approach in mind, but the room won't allow it so I'd like to use the raise-of-hands approach, low tech. I'll give each of you two votes because you've got two hands. You're going to -- you can spend both of those on a single option if you wish.

I'd like to go through each topic in turn. Expend your votes on your sense of priority. And I will just tabulate them, and we'll take them back and have those priorities in mind as we formulate a proposed schedule for you.

So let me take -- so the notion is I'll mention a topic. I'll ask you to vote. You're on your honor to vote no more than twice for all these topics, but you can vote twice for a single topic if you wish to.

The first, enhancing consumer

protection, if I could just get a show of hands for the level of interest. Okay.

DR. SPURLOCK: Can I ask a question?

DR. ROMERO: Yes.

DR. SPURLOCK: Are we supposed to be voting today?

DR. ROMERO: This is an advisory vote. I have not -- nobody has rebuked me about my --

MS. BOWNE: Expression of level of interest.

DR. ROMERO: Exactly. So can I have a show of hands?

MR. LEE: Wait.

MS. MURRELL: Wait. We have to clarify.

DR. ROMERO: Sure.

MS. MURRELL: Based upon his conversation and the other conversations regarding quality of care, when we talk about quality of care now, are we talking about both information and 3A, which is the impact on quality of care?

I mean, I don't know what I'm voting for when I'm talking about improving quality of care.

DR. ENTHOVEN: Impact of managed care on quality is a statutory requirement.

MS. MURRELL: Okay.

DR. ENTHOVEN: We're going to have to --

MS. MURRELL: So we will do both of those? We'll talk about information as well as the impact?

DR. ROMERO: Yes.

DR. ENTHOVEN: Right.

DR. ROMERO: And actually --

MR. LEE: I think you moved it over.

DR. ROMERO: I think the first one is the most logical place for that. Sorry. The quality of care is the most logical place for that. And as Alain said, that is a statutory requirement and clearly an important topic.

So, again, with you having a total budget of two hands among all these open picks, but you can exercise both hands for a given topic if you think it is really, really important, can I get a show of hands for the first one, enhancing consumer protection? Make that one -- seven. Plus Jeanne makes eight.

Okay. The regulatory organization, in essence, what we've been talking about today. One, two, three. Three. Okay.

Quality of care? One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve. You've got two? Is that a two, or is that a one?

MR. KERR: It was one.

DR. ROMERO: I lost count. Can you

hold them up? Three, four, five, six, seven, eight, ten, eleven, twelve, thirteen. All right.

MS. SKUBIK: That's all the present members; right?

DR. ROMERO: Yeah. Increasing choice among plans, not within plans but among plans. One, two, three.

Including choice within plans, which, as I understand it - Hattie, correct me - are things like point-of-service options. Right?

MS. SKUBIK: Within plans -- that could be a way. Or just referring to specialists internally. I that was more of an Alain entry.

DR. ENTHOVEN: Of course, what's happening is there is a lot of innovation going on in the marketplace as different HMO's are working to change their processes in the ways to satisfy the concerns of their members upon the issue of access to specialists, et cetera. So it may be that we can reasonably give that a low priority on the grounds the market is working there.

DR. ROMERO: As long as we can convince ourselves that the government is not impeding useful intervention.

DR. ENTHOVEN: Right.

DR. ROMERO: I'm sorry. Did I take a count there? Zero? Zero? Zero.

And, finally, industry restructuring?

Is that a vote or --

MS. BOWNE: Yeah, for industry restructuring. No, it's a preference choice.

DR. ROMERO: I'm sorry. An expression of preference, not a vote. So one. Anybody else?

DR. ENTHOVEN: In a way, this is a prescribed paper. This is a description of item one in Richter.

DR. ROMERO: But, again, even within the prescriptions we have some choice about some things.

DR. ENTHOVEN: Right.

DR. ROMERO: All right. We will be using this and planning some proposed meeting schedules with your preferences in mind.

Go ahead, Alice.

MS. SINGH: I just wanted to mention one thing. The members who were unable to attend today's meeting will also have an opportunity to exercise their interest in priorities and so forth. We will be sending this out to them and asking them to vote. Excuse me. Not vote, to --

DR. ROMERO: You of all people.

MS. SINGH: I can't believe it.

-- to express their interest in their priority.

MR. ROMERO: I'd be really stunned if the reports changed significantly.

I think with that I'm done.

Mr. Chairman, I'll turn it back over to you.

DR. ENTHOVEN: Okay. We're about --

DR. RODRIGUES-TRIAS: Just one very quick -- on this issue, obviously, we have a lot of interest in including quality of care. Could we get some materials from some of the states that are maybe more advanced than we are in developing some of the data bases? I'm thinking of Minnesota in particular in looking at outcomes or Washington state. There are some states that are doing more than we are.

MS. BOWNE: I think that's a political issue as to whether they're more advanced or more retarded.

DR. ENTHOVEN: No.

DR. RODRIGUES-TRIAS: All right. I won't use a hierarchical term. I will just say who are doing a lot out there.

DR. ENTHOVEN: Your point is a good one. I'd love for people to see what New York is doing on risk adjusted mortality for bypass surgery, which I wish we could do here.

DR. RODRIGUES-TRIAS: I guess I'm sort of very taken by the Minnesota model because they are looking at outcomes measuring the totality of their population irrespective of what the coverage is. And I think that's very enticing.

DR. ALPERT: There are some other things about Minnesota that are very unusual too. I agree with that.

DR. ENTHOVEN: Okay. We have friends and sources there.

DR. ROMERO: Are those two different categories?

DR. ENTHOVEN: Some of us can speak Minnesotan.

Well, I think we've probably exhausted ourselves. Would members of the public join us at San Diego City Counsel Chambers, 202 "C" Street, which is supposed to be about four blocks from here. And then the task force members will just sit and listen while the public speaks.

Okay. Meeting is adjourned.

(The proceedings adjourned at 5:00 P.M.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN DIEGO)

I, Susan M. Kline, CSR 4617, a Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing proceedings were taken down by me in shorthand at the time and place named therein and were thereafter reduced to typewriting under my supervision and that this transcript is a true record and contains a full, true and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

EXECUTED this 18th day of June, 1997.

Susan M. Kline, CSR 4617